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ABSTRACT

Youth suicide is becoming a vital, compelling issue to citizens, their families, and professional and legislative groups. Although schools are second only to families in responsibility for children's welfare, few schools have formal policies and procedures for preventing student suicide or dealing with its aftereffects. Also, numerous myths abound regarding suicide's etiology and warning signals. This monograph documents the results of a 1986 statewide survey of Texas school superintendents concerning the status of existing school policies and procedures. After reviewing the work of Charlotte Ross, Pamela Cantor, and other suicidologists, the report presents some statistics demonstrating a steady rise in the rate of youth suicide within the last 15 years; the data also shows that between 1970-1980, in Texas, reported suicide rate for 10.1 per 100,000, compared to the national rate of 8.5. Responding superintendents did not consider youth suicide a particularly important topic for inservice education or for school professionals' consideration. As a group, they thought external agencies should take leadership roles in this area. Only 4 out of 356 superintendents said their districts had written policies and procedures addressing the problem. After summarizing recent legislation, the paper urges further state legislative action to develop and implement written school policies. Several recommendations are made concerning this legislation, including provision of a training component for school professionals. In addition to the study instruments, appendixes include exerpts from a 1983 congressional hearing on youth; youth suicide legislation from four states; a resource list; and the relevant sections of the Texas Family Code. Sixty-three references are also included. (MLH)

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Center for Policy Studies and Research
in Elementary and Secondary Education

Frank W. Lutz, Center Director

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YOUTH SUICIDE: The Identification of Effective Concepts and Practices in Policies and Procedures for Texas Schools

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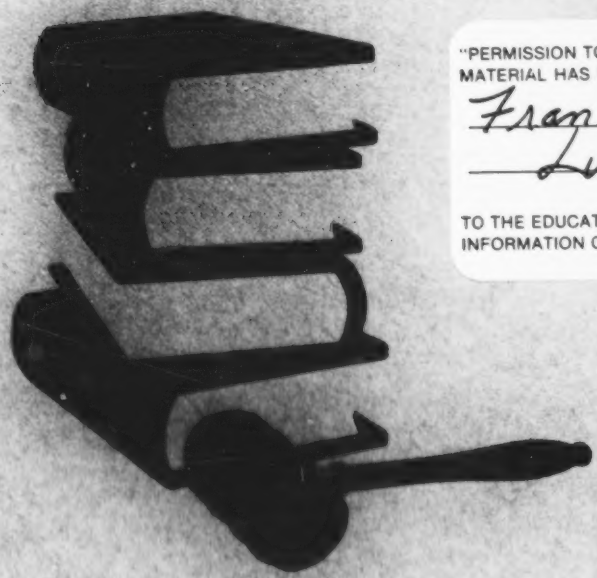

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EAST TEXAS STATE UNIVERSITY

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PREFACE

Youth suicide is a vital and compelling issue to individual citizens and their families as well as professional and legislative groups. The topic can be sensationalized by the media, creating mistaken assumptions about the nature of this psychological crisis in our young people's lives and can even promote further casualties among other youngsters already "at risk" (Gould & Shaffer, 1986; Phillips & Carstensen, 1986). Helping professionals, be they counselors, social workers, psychologists, or psychiatrists, have begun to recognize the benefits of specialized training in the field of suicidology. Yet, often the organization most closely linked for the most extensive period of time and with the highest ratio of professionals to children and youth has yet to formalize its policies and procedures with regard to this appalling possibility in the lives of an increasing number of young people. Unless a school has already experienced an individual or a cluster suicide, virtually no preparation appears to exist, no procedures stand ready to be put into effect, and a number of myths appear to continue to be perpetuated regarding the etiology and warning signals of suicide. The death of any child is a difficult event for everyone in a community but should that death be a suicide it "rapes our sensibilities" (Berman & Carroll, 1984).

This monograph was written to serve as a point of departure for legislative and professional discussion on the

current status of school policies on youth suicide in the state of Texas. Our hope is to identify possible productive directions for the development of appropriate policy as well as to illustrate a critical area of individual despair that can exist in young people's lives in Texas.

INTRODUCTION

This monograph documents the results of a statewide survey of Texas school superintendents conducted between February and July, 1986. The purpose of the survey was to establish the current status of existing school policies and procedures with regard to youth suicide in Texas. Additional information was sought in terms of perceived beneficial leadership in governmental and local groups and among a variety of individuals, both professional and non-professional.

There has been a growing concern among legislators about the problem of youth suicide (Appendix A). At the national level, this concern contributed to the Youth Suicide Prevention Act (Bill HR 4650) which was passed by the Federal House of Representatives and referred to the Senate Subcommittee on Education, Arts and Humanities (July, 1986). Should this bill pass the Senate, be finalized by Conference Committee, and signed by the President, there would also be a federal commitment to combating this problem.

At the state level, youth suicide legislative policies are already in effect in California, Wisconsin, Alabama, Florida, and New Jersey (Appendix B). A content analysis of the components and programs being utilized by these states demonstrates commonalities and differences in the various approaches. Several recommendations for legislative action

in Texas have been made based on this information.

Those who will eventually benefit from this project should be young people, their families, and their teachers. The quality of life for young people, their affective and intellectual development, their aspirations, and their hopes are worthy of our efforts. Their lives are their future but also a community's collective legacy.

YOUTH SUICIDE: AN OVERVIEW

Government hearings, beginning with those of the Select Committee on Children, Youth, and Families in 1983 and culminating in Hearings on the Youth Suicide Prevention Act in 1985, have provided suicidologists with an opportunity to describe the problem of youth suicide. Their testimony is extensive, and therefore the opinions of two key professionals are used as an introduction to the overview.

Charlotte Ross (Co-chair, National Committee for Youth Suicide Prevention; Director, Youth Suicide and Crisis Center of San Mateo County, California), in her testimony before the Sub-committee on Juvenile Justice in April, 1985, stated her belief that the United States can "turn back the tide of youth suicide." The components of successful efforts in this regard would include a variety of programs to increase awareness in both young people and the general public as well as creating statewide clearinghouses for information and data. She emphasized the necessity of specialized programs for helping professionals in general and juvenile detention facilities staff in particular. In this latter area, she described a pressing need to train facility staff in the identification, assessment, and management of suicidal youth and to review existing protocols.

Pamela Cantor, President of the American Association of Suicidology in 1985, has spent 16 years in suicide research, treatment, and public education. She describes suicide as a national problem which selectively affects this nation's

youth. The mortality rate during the last 20 years has decreased for every age group except those 15 to 24 years old. Two types of death have been found responsible for the increase among adolescents and young adults: suicide and homicide. Cantor estimates that at least 5,200 adolescents kill themselves every year. That is one every 90 minutes. Further, she has suggested that in all probability 500,000 adolescents attempt suicide every year, a startling one attempt every minute!

Cantor makes two specific recommendations to deal with the problem. First, she advocates school based suicide prevention programs for both students and teachers. These school programs should be matched by community education for parents. She estimates that self-inflicted mortality would be reduced by 20% as a result of this public education. However, Cantor does admit to the inherent problems of evaluation procedures for these programs. Her second recommendation is that every effort should be made to limit the availability of lethal agents, particularly firearms.

Since guns account for approximately 60% of teen suicides and female adolescents are increasingly using firearms for suicide, Cantor's advice is critically important for the American public. She estimates that out of 25 million households owning guns some 12 1/2 million keep them loaded. For the suicidal adolescent, a loaded gun available within his/her home could be a lethal solution that is difficult to ignore. Cantor advocates both mandatory safety training and public education. Apparently

when highly lethal methods are made less available to adolescents, they do not switch to some other possibility (Frederick, 1985, p. 9). This inability to be flexible in method of choice has been found among other populations. Several years ago, the United Kingdom began using natural gas instead of lethal coke gas for domestic purposes. The suicide rate dropped by 33% and has not risen again despite the most serious economic depression in that nation's history.

Cantor suggests that if the medical community were to monitor and place limits on prescriptions, then some impact could also be made on the 11.3% of suicides who choose poisoning/ingestion as a method of choice. By providing an emetic or antidote with prescribed drugs (for example, tricyclic antidepressants) a further safeguard against death would be available within the home.

Cantor recognizes that a "cultural pervasiveness" of violence in this country, coupled with considerable emotional neglect and stress among young people, places far too many of them at risk. Where the focus is on intervention, however, then her recommendations of limiting the availability of firearms and medication and providing quality public education programs can have significant results in terms of lowering the death rate among 15 to 24 year old young people.

Effective remediation and prevention of youth suicide depend on an accurate assessment of the problem both at the state and local level. However, accurate assessment itself

depends on a meaningful definition of suicide (Shneidman, 1985).

Gould and Shaffer (1986) suggest that suicide is determined by three factors: biologic predisposition, experience, and environment. Berman and Carroll (1984) carried out a comprehensive review of research studies which employed a control group, statistical analysis, and an operational definition of "attempt suicide." These suicidologists warn that the resultant emergence of demographic features, behavioral characteristics, family/parent characteristics, cognitions, and psychopathology should not be used as a predictive checklist. Rather these categories of characteristics can be useful in learning how to think about suicide rather than predicting which individuals are at risk.

Joan (1986) writes that teenagers consider their lives to be fraught with unrealistic expectations and stresses involving career choice, familial rejection and loss, high achievement, and simply being a teenager in today's world. She adds that increased vulnerability comes from family histories of alcoholism and physical/sexual child abuse.

Maris (1985) notes that while young suicides share with older suicides features such as "high and repeated depression, their profound sense of hopelessness, use of guns to suicide, social isolation, and viewing death as . . escape from intolerable problems," there are unique features which demand closer examination:

> Youth suicides . . . are more revenge motivated, anger, irritation, and impulsivity-based, have more negative interpersonal relations, make more non-futile attempts, have more suicides and divorce in their family of origin, and are less likely to have financial, work, or marital resources, involve more risk taking, excessive drug and alcohol use, and are more likely to be romantic and idealistic, have lower self esteem, and fewer life accomplishments. (p. 108)

The Seventeenth Annual Survey of High Achievers conducted by Who's Who Among American High School Students in the spring of 1986 reveals that 46% of teen achievers knew a young person who had tried to commit or had committed suicide and 31% had considered it themselves. (Lindegard, 1986). The factors that teen achievers believed contribute most to suicide are: a feeling of personal worthlessness (86%), feelings of isolation and loneliness (81%), and pressure to achieve (72%). Family influences cited include: lack of communication between teens and parents (58%), lack of attention from parents (50%), and a lack of stability in the family (49%). When asked to identify solutions to the problem, these teen achievers suggested both awareness-education and counseling. Seventy-one percent supported suicide awareness programs for teens and parents, 68% chose suicide/crisis intervention hot lines, and 61% the availability of private counseling in the schools.

These young achievers voiced opinions and beliefs remarkably similar to those of recognized professionals in suicidology. Judie Smith, Program Director for the Dallas Suicide and Crisis Center, has suggested that rapid suburban growth andchange are associated with elevated levels of

stress. Relocating families have less access to the "extended family" for support, and their children find themselves in new schools requiring them to re-establish friendship networks. The often unrealistic and extreme emphasis on personal and professional success demonstrated by these upwardly mobile communities become unfortunate models for young people.

> Accomplishments and success or failure directly influence self esteem. Suicidal individuals have a feeling of worthlessness. "Low self esteem" translates into "worthlessness." (Hearing before the Select Committee on Children, Youth and Families, 1983)

Berman (1986) advocates that members of helping professions respond to an adolescent-at-risk by utilizing a "process" rather than a "content" focus and thereby determine what the suicide communication may mean to that youngster. Viewed from this perspective, the suicidal adolescent's intention is to leave life as s/he knows it, a life that is problematic and painful, and to escape from unbearable feelings of helplessness and despair. It is escape, not death, that is attractive. That these young people are unable to see any other choice reflects their severely constricted thinking patterns during a time of crisis.

By combining philosophy, personality, and systems theory, Shneidman also provides a redefinition of suicide in which the incident is seen as an idiosyncratic event (1985). He suggests, however, that there are ten salient characteristics which pertain to suicide at any age. These

relate to individuals' feelings about the meaning of life and notions about death, their threshold for frustration and psychological needs, and the interlocking characteristics of the societal or familial system in which they live.

TABLE 1

Aspect	Common Characteristic	Based On	Relieved By
Situational	1. Stimulus	psychological pain	reducing the pain
	2. Stressor	frustrated psychological needs	filling the frustrated needs
Conative	3. Purpose	to seek a solution	providing a viable answer
	4. Goal	cessation of consciousness	indicating alternatives
Affective	5. Emotional	hopelessness/ helplessness	giving transfusions of hope
	6. Internal Attitude	ambivalence	playing for time
Cognitive	7. Cognitive State	constriction	increasing the options
Relational	8. Inter-personal Act	communication of intention	listening to the cry, involving others
	9. Action	escape	blocking the exit
Serial	10. Con-sistency	life-long coping patterns	involving previous patterns of successful coping

Source: Shneidman, 1985, (pp. 123-149, 231-232).

Table 1 illustrates the usefulness of Shneidman's

model. Primarily there is no simple cause and effect relationship for suicide. Rather, suicide provides evidence of a "multifaceted event" (p.202) in which all aspects of experience contribute to the development of several common characteristics. Almost all of these could be communicated to a concerned adult. There are useful implications here for the prevention of and responses to an adolescent-at-risk.

Shneidman also refers specifically to the importance of accurate assessment of lethality (deathfully suicidal behavior) and levels of perturbation (upsetness). High lethality (for example the ready availability of a loaded gun) coupled with elevated perturbation (extreme distress) and unusually constricted thinking ("there is no other choice") is a dangerous combination providing the essential ingredients for a successful suicide. The most effective way to reduce lethality is to do what is necessary to reduce the anguish and tension the young person is experiencing.

A review of a number of resources and planning guides developed by organizations and schools throughout the United States (Appendix C) suggests that the following general principles ought to be borne in mind:

1. Youth suicide can be precipitated by an acute crisis which may involve conflict with parents, difficulties in school, and problems with a significant relationship. These can be the circumstances, but these are not the cause.
2. Young people in a suicidal crisis have feelings of

anger, hopelessness, helplessness, haplessness, despair, and loneliness. These can be intolerable when not communicated and shared by others.

3. When young people experience loss of a relationship, their hurt may seem out of proportion to adults, but they have no backlog of life experiences on which to draw or gain comfort. Without the ability to communicate their loss and without that loss being empathically understood, their sense of isolation can seem desperate.
4. When young people are in a suicidal crisis, they appear to wear cognitive "blinders" which cause them to be unable to generate options that are not lethal and self-destructive. If their history has been devoid of experiences and training in making choices during less stressful times, they are lacking a critical life skill. They are what Berman (Austin MHMR Conference, 1986) describes as "lousy problem solvers." The experiences of learning to solve far less threatening problems at a simpler level is another life skill that serves all adolescents well as they grow up.

In sum, there are responses to a suicidal adolescent which can be taught to parents, teachers, counselors, and peers which can literally provide a lifeline until more formal avenues of professional help can be brought into place. In addition, there are life skills which must be taught to all children, and in all likelihood to adults as

well, which would provide access to healthy emotional and cognitive development: choice-making and decision strategies, problem solving (particularly at the interpersonal level), communication skills (both listening and responding), and an understanding of grieving and loss.

EPIDEMIOLOGY: TEXAS AND U.S.A.

The Center for Disease Control (CDC) using Annual Mortality Files from the National Center for Health Statistics has summarized the incidence of suicide in the U.S.A. for the 11-year period, 1970-1980. During 1985-1986, their Violence Epidemiology Branch compiled a report of statistical information on suicide deaths and a companion statistical report focusing on youth suicide as a part of a series of proposed periodic suicide surveillance reports. From this resource we can illustrate both the national picture and a more detailed description of the Texas statistics.

Although our report focuses on the plight of suicidal youngsters in Texas' public schools, the data in Table 2 demonstrates quite clearly that the greatest proportion of suicides among the young are to be found in the 20-24-year-old age group. At the national level, the rate for this age group has increased from 12.2 (rates in this report are per 100,000 population) in 1970 to 16.1 in 1980.

In the 15 to 19-year-old age group, the rate increased from 5.9 in 1970 to 8.5 in 1980. When these two rates are reported by sex, males have the highest suicide rates, rising from 8.8 in 1970 to 13.8 in 1980 (Table 3).

TABLE 2

NUMBER OF SUICIDES AND SUICIDE RATES FOR ALL PERSONS 15-24 YEARS OF AGE BY AGE GROUP, GEOGRAPHIC REGION, AND YEAR: U.S. 1970 AND 1980

	15-19y		20-24y		TOTAL 15-24y	
NORTHEAST						
1970	(197)	4.6	(362)	9.8	(559)	7.0
1980	(313)	6.9	(615)	14.2	(928)	10.5
NORTH CENTRAL						
1970	(297)	5.5	(467)	10.6	(764)	7.8
1980	(483)	8.6	(857)	15.4	(1,340)	12.0
SOUTH						
1970	(294)	4.8	(539)	10.2	(833)	7.3
1980	(611)	8.6	(1,169)	16.4	(1,780)	12.5
WEST						
1970	(335)	10.2	(637)	21.0	(972)	15.3
1980	(390)	10.0	(801)	18.7	(1,191)	14.5
TOTAL						
1970	(1,123)	5.9	(2,005)	12.2	(3,128)	8.8
1980	(1,797)	8.5	(3,442)	16.1	(5,239)	12.3
U.S.A.						
1970	ALL AGES				(23,480)	11.6
1980	ALL AGES				(26,869)	11.9

Source: National Center for Health Statistics Annual Mortality Data Files: U.S. Bureau of the Census Population Estimates

TABLE 3

SUICIDE RATES FOR ALL PERSONS 15-24 YEARS OF AGE BY AGE GROUP AND SEX

		15-19y		20-24y		TOTAL 15-24y	
U.S. TOTALS							
1970	males	(851)	8.8	(1,527)	19.2	(2,378)	13.5
	females	(272)	2.9	(478)	5.6	(750)	4.2
1980	males	(1,483)	13.8	(2,853)	26.8	(4,336)	20.2
	females	(314)	3.0	(589)	5.5	(903)	4.3

Source: National Center for Health Statistics Annual Mortality Data Files: U.S. Bureau of the Census Population Estimates

By state and geographic region of the country (Table 4), suicide rates among high school students in 1980 ranged from a low of 5.0 in Alabama to a high of 16.1 in Montana and Alaska. Hawaii's reported rate of 4.6 may be misleading since death by suicide in that state is only recorded when written records produce unmistakable evidence to support that classification.

TABLE 4

NUMBER OF SUICIDES AND SUICIDE RATES FOR ALL PERSONS 15-19 YEARS OF AGE BY GEOGRAPHIC REGION AND STATE FOR 1980

1980	HIGHEST			LOWEST		
Northeast	Vermont	(7)	13.6	Massachusetts	(31)	5.7
North Central	N.Dakota	(10)	15.6	Iowa	(17)	6.1
South	Louisiana	(47)	11.0	Alabama	(19)	5.0
West	Montana	(12)	16.1	Utah	(11)	7.9
	Alaska	(.6)	16.1	Hawaii	(4)	4.6

Source: National Center for Health Statistics Annual Mortality Data Files: U.S. Bureau of the Census Population Estimates

The CDC reports "a marked increase in the contribution of young white male suicide deaths to the national suicide problem since 1970." The rates for this high school group, that is among young white males 15 to 19 years old, increased by 60% during the period 1970 to 1980.

Firearms appear to be the preferred method of suicide not only among young white males but also among males and females of both white and black racial groups. The implication appears to be that there is a move away from

poisoning, a previous method for females, towards a more lethal option where there is far less opportunity for intervention (Center for Disease Control, 1986).

When the combined age groups for young people (15 to 24 years old) are compared for 1960 and 1980, the increase in youth suicide becomes even more dramatic, soaring 136% (5.2 to 12.3). However, this increase may not be epidemic but a reflection of the "true prevalence of adolescent suicides" (Maris, 1985). Berman (Newslink, 1985) cautions that to continue to describe the increase in catastrophic terms does not recognize the 9% decline that took place between 1977 and 1982. Nevertheless, youth suicide is viewed by the U.S. Department of Health and Human Services as a serious enough problem to warrant a specific health objective: "By 1990 the rate of suicide among people 15 to 24 years of age should be below 11 per 100,000 compared with 12.4 per 100,000 in 1978" (Center for Disease Control, 1986, p. 6).

Throughout the 11-year period, there appears to be a steady increase in the rate of reported suicides among young people 15 to 19 years old in the State of Texas (Table 5). By 1980, Texas was above the national reported rate, i.e. 10.1 compared to 8.5 per 100,000. The Texas Bureau of Vital Statistics reported that by 1985 the suicide rate was 11.1, with 149 reported deaths. The rates for white males, white females, black males, and black females for this age group

TABLE 5

TEXAS 15-19 YEAR OLDS, 1970-1980

Year	Suicide Rates	Numbers of Suicides
1970	5.7	63
1971	7.3	82
1972	6.6	76
1973	7.7	91
1974	8.0	97
1975	8.6	106
1976	9.1	115
1977	10.3	131
1978	9.0	115
1979	Rate not calculable because population estimates were not available	
1980	10.1	136

Source: National Center for Health Statistics Annual Mortality Data Files: U.S. Bureau of the Census Population Estimates

were 18.6, 4.2, 12.0, and 3.4, respectively. These descriptive statistics demonstrate that the problem of youth suicide in Texas tends to reflect the national picture. There has been a steady and appreciable rise in the rate of youth suicide within the last 15 years. While the numbers and rates reported do not suggest that Texas is within the "highest" category for youth suicide in the nation, neither can this state claim that the reported rates for this age group are not a reflection of a serious problem.

Reported rates may not even adequately represent the true number of suicide deaths. Accurate certification may be difficult to obtain when there is insufficient evidence

on which to make a determination of suicide, or when evidence is "either consciously or unconsciously" withheld to avoid the stigma associated with suicide. Death may be recorded as an accident or a suicide depending on the interpretation made by the medical examiner, coroner, or physician. Finally, no death certificate can be filed if the body is never found (Center for Disease Control, 1986). Therefore, the numbers and rates in this report should be viewed as a baseline estimate until more accurate death certificates are designed. Estimates of attempted suicides have now been placed at approximately 110 for every completed suicide. Smith and Crawford (1986) concluded from their study of 313 high school students in the Midwest that:

> suicide is a personal concern of most high school students and a serious concern of 1 out of 4 of these students. From 1 out of 8 to 1 out of 12 high school students have actually made an attempt.

Although these figures may seem high, they appear to be supported by other studies quoted by Smith and Crawford. These authors suggest that attempts to help troubled adolescents should not be narrowly focused only on the seriously suicidal! We must acknowledge that most high school students in Texas need our attention.

These statistics on youth suicide, at both national and state levels, support a recommendation for appropriate prevention, intervention, and postvention policies and procedures in our school systems.

SURVEY OF TEXAS SCHOOL SUPERINTENDENTS, 1986

PURPOSE

The primary purpose of this study was to establish:

(1) the current status of existing school policies and procedures with regard to youth suicide in Texas;

(2) the current level of knowledge school superintendents possess about youth suicide; and,

(3) superintendents' beliefs about beneficial leadership among a variety of institutions and individuals (Appendix D).

A survey of 1,068 public school superintendents in the state of Texas was carried out during June and July, 1986. We anticipated that those superintendents reporting suicide deaths among the students in their districts and those reporting no deaths would differ in their responses to the questions.

In addition to the survey of superintendents, a mini-survey of mental health center directors in Texas was conducted during September and October, 1986. The mini-survey sought the directors' views concerning appropriate school and community responses to youth suicide (Appendix E).

PROCEDURES

The survey of superintendents was mailed to all 1,068

school superintendents in the State of Texas. Of the school districts listed by Texas Education Agency, 24 were eliminated from the survey because these consisted of specialized residential populations with unique traits and psychosocial problems. Superintendents of Independent School Districts were selected to receive the questionnaire because they were deemed to be the persons most likely to possess knowledge of existing school-based suicide prevention policies and programs. In small school districts, the superintendent may be the sole district administrator. In addition, school superintendents are a vital link in any community response to youth suicide. Therefore, their views are critical in understanding the present situation and in developing any school-based response to youth suicide.

Since establishing the current status of existing school policies and procedures with regard to youth suicide was a central purpose of this study, initial efforts were focused on motivating a high rate of response to the survey. Both the design of the survey booklet and the plan of repeated contacts were aimed at maximizing responses. Most of the questions were direct, and the response tasks were easy. The survey booklets emphasized the importance of the study to the people of Texas and were pre-addressed and stamped, thereby requiring potential respondents to simply fill it out and drop it in the mail.

Borg and Gall (1979) have pointed out the importance of repeated contact with nonrespondents (p. 305). The

population of superintendents was contacted four times to encourage their response. First, a pre-survey letter was mailed to all 1,068 superintendents of non-residential public schools in the state. This letter described the work of the Center for Policy Studies and Research in Elementary and Secondary Education and the purposes of the suicide project. It stressed the importance of the study to the youth of Texas and requested their response upon receipt of the survey booklet.

The survey was mailed one week later. It included another letter which briefly described the purposes and importance of the study. The superintendents were encouraged to respond within 2 1/2 weeks of receiving the questionnaire. A postcard was mailed a week after that to all superintendents. The postcard was a "reminder" of the survey, and it asked superintendents to respond if they had not already done so. Finally, a letter was mailed to all nonrespondents one month later. This letter stressed the importance of the superintendents' responses and asked them to contact us if they wanted a new survey booklet.

In addition to the mail survey of superintendents, a telephone survey of the directors of the 39 mental health/mental retardation centers listed in Texas Department of Mental Health and Mental Retardation Directory of Services, '86 (TDMHMR, 1986) was conducted in September and October, 1986. The survey sought these directors' views concerning appropriate school and community responses to youth suicide.

We believe that effective policies for youth suicide pre-, inter-, and postvention will link up professionals within a community from a number of disciplines to form a response nexus. Therefore, the views of these mental health professionals were deemed to be both significant and important.

METHOD

One of the primary purposes of this study was to establish the current status of existing school policies and procedures with regard to youth suicide in Texas. A secondary purpose was to identify any existing links between regional MHMR agencies and the public school systems for responding to youth suicide. These purposes necessitated a survey of the total populations of school superintendents and MHMR agency directors. Additionally, the knowledge of and beliefs about youth suicide were sought from each group. The following descriptive information was sought:

(1) How many school districts in Texas have existing school policies and procedures regarding youth suicide?

(2) How accurate is the knowledge of school superintendents about the incidence of youth suicide by age group, ethnic group, and method?

(3) What are the beliefs of school superintendents about persons or institutions that should be involved in community responses to youth suicide?

(4) How and to what extent are regional MHMR centers

involved in suicide pre-, inter-, and post-vention?

(5) What are the beliefs of MHMR directors about the importance of a school-based response to youths in suicidal crisis?

The response rate of school district superintendents was distributed evenly across the state by geographic, urban/rural, and refined average daily attendance (RADA) classification.

It was hypothesized that the views of superintendents reporting youth suicide deaths in their districts would differ from those reporting no suicide deaths in their districts on three issues: (1) the comparative importance of youth suicide to these schools as a psychosocial problem; (2) the institutions that should provide leadership in responding to youth suicide; and, (3) the individuals who could provide leadership in a community response to youth suicide. Superintendents were asked to rank order a number of possible responses to each question. A split-median test was used to determine differences, if any, in the rankings of the two groups (those reporting suicide deaths and those reporting no suicide deaths).

RESULTS

Superintendents' Survey

Of 1,068 non-residential independent school districts contacted, 356 (33%) responded to the questionnaire. As shown in Tables 6 and 7, the response was representative of all school districts based on average daily attendance and urban/rural classification.

Table 6

RESPONSE TO SURVEY ACCORDING TO SCHOOL DISTRICT SIZE*(RADA)

1984-85 RADA	Number of School Districts within Grouping	Number of Districts within Grouping That Responded	% of Responding Districts within Grouping
Over 25,000	19	7	36.8%
10,000-24,999	43	16	37.2%
5,000-9,999	33	15	45.4%
1,000-4,999	91	31	33.3%
1,600-2,999	118	40	33.9%
1,000-1,599	117	49	41.9%
500-000	201	80	39.8%
Under 500	446	118	26.6%
TOTAL	1,068	356	

*RADA = Revised Average Daily Attendance

Table 7

RESPONSE TO SURVEY ACCORDING TO SCHOOL DISTRICT CATEGORY

*District Category	Number of Districts	ADA	Number Responding to Survey	% of Category Responding to Survey
Urban	8	37,092-175,609	3	37.5%
Central	31	4,066-11,836	12	38.7%
Suburban/Fast Growing	87	959-39,547	26	29.9%
Suburban/Stable	66	983-36,812	21	31.8%
Non-Metro 1000+	208	909-10,699	84	40.4%
Non-Metro Town	233	132-1,595	95	40.7%
Rural	432	6-1,468	115	26.6%
Not Listed	3**		0**	
TOTAL	1,068		356	

*TEA Statistical Brief SB84(5): Fall Survey of Students in Texas -- Public Elementary and Secondary School Districts 1983-84.

**Discrepancies are due to an artifact of the school districts' classifications.

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Of the 356 superintendents responding, 55 (15%) reported at least one youth suicide in their district during the 2-year reporting period. A total of 81 suicide deaths was reported (Table 8). Seventy-three (20.5%) of the superintendents reported suicide attempts among young people in their school district during the reporting period (Table 9). A total of 476 attempts was reported.

Table 8

SCHOOL SUPERINTENDENTS' ESTIMATES OF SUICIDE DEATHS

FOR 2-YEAR PERIOD (Fall, 1983 to Spring, 1985)

Number of School Districts Reporting	Frequency of Suicide Deaths Reported by School District	% of School Districts Reporting Each Frequency
301	0	84.6
41	1	11.5
9	2	2.5
1	3	.3
2	4	.6
1	5	.3
1	6	.3
356		100.0

Total Deaths Reported = 81

Table 9

SCHOOL SUPERINTENDENTS' ESTIMATES OF SUICIDE ATTEMPTS

FOR 2-YEAR PERIOD (Fall, 1983 to Spring, 1985

Number of School Districts Reporting	Frequency of Suicide Attempts Reported By School District	% of ISDs Reporting Each Frequency
283	0	79.5
30	1	8.4
14	2	3.9
8	3	2.2
2	4	.6
7	5	2.0
2	6	.6
2	7	.6
1	8	.3
2	9	.6
1	10	.3
2	12	.6
1	15	.3
1	250	.3
356		100.0%

Total Attempts Reported = 476

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Forty-three of the reported suicide deaths occurred among males aged 10 to 19 years old. (School superintendents reported a total of 81 deaths in Question II part 1. Question II parts 2, 3, and 4 requested a breakdown by age, gender, method, and race. A number of superintendents did not respond to Question II and, therefore, this analysis will deal with a total of 55 deaths. Similarly the analysis of attempts by age, gender, method, and race deals with 402 of the reported 476 attempts.) Forty-five deaths were reported for the 15 to 19-year-old age group (Table 10). Of the 402 attempts reported, 145 were by males, and 257 were by females. Two attempts were reported for children aged 5 to 9 years, 143 for the 10 to 14-year-olds, and 257 for the 15 to 19-year-olds (Table 11).

Table 10

SCHOOL SUPERINTENDENTS' ESTIMATES OF

SUICIDE **DEATHS** BY **AGE AND GENDER** (Fall, 1983 to Spring, 1985)

	MALES						FEMALES					
	AGES 5-9		AGES 10-14		AGES 15-19		AGES 5-9		AGES 10-14		AGES 15-19	
DEATHS	ISDs	TOTALS	ISDs	TOTALS	ISDs	TOTAL	ISDs	TOTALS	ISDs	TOTALS	ISDs	TOTALS
0	337		329		307		337		335		330	
1			8	8	25	25			2	2	5	5
2					5	10					1	2
3											1	3
*NR	19		19		19		19		19		19	
TOTAL	356	0	356	8	356	35	356	0	356	2	356	10

*Not Reporting

Total Suicide Deaths Reported = 55
(for 2-year period)

Total Suicide Deaths Recorded by Texas Vital Statistics
1983-84 = 338

Table 11

SCHOOL SUPERINTENDENTS' ESTIMATES OF

SUICIDE **ATTEMPTS** BY **AGE AND GENDER** (Fall, 1983 to Spring, 1985)

	MALES						FEMALES					
	AGES 5-9		AGES 10-14		AGES 15-19		AGES 5-9		AGES 10-14		AGES 15-19	
ATTEMPTS	ISDs	**TOTALS	ISDs	**TOTALS	ISDs	**TOTALS	ISDs	**TOTALS	ISDs	**TOTALS	ISDs	**TOTALS
0	334		328		312		334		315		299	
1	1	1	4	4	13	13	1	1	12	12	23	23
2			2	4	4	8			2	4	5	10
3					2	6			3	9	3	9
4					1	4					2	8
5					1	5			2	10	1	5
6											1	6
10					1	10						
30			1	30								
60					1	60						
70									1	70		
90											1	90
*NR	21		21		21		21		21		21	
TOTAL	356	1	356	38	356	106	356	1	356	105	356	151

*Not Reporting

**Totals = Attempts X Number of School Districts Reporting

Total Suicide Attempts Reported = 402 (145 Male; 257 Female)

(Estimated attempts in these age groups in 2-year reporting period = 33,800)

The methods employed in the 55 suicide deaths were firearms and explosives (32), poisoning (3), and hanging/strangulation/suffocation (13). There was no information on the method employed in the remaining seven deaths (Table 12). A large number of attempts were reported as car accidents (an "other" category), while poisoning was used in 156 attempts, firearms in 14 attempts, and there were 13 attempts by hanging/strangulation/suffocation (Table 13).

Table 12

SCHOOL SUPERINTENDENTS' ESTIMATES OF

SUICIDE **DEATHS** BY **METHOD** (Fall, 1983 to Spring, 1985)

DEATHS	FIREARMS AND EXPLOSIVES		POISONING		HANGING/STRANGULATION/ SUFFOCATION		ALL OTHER MEANS	
	ISDs	**TOTALS	ISDs	**TOTALS	ISDs	**TOTALS	ISDs	**TOTALS
0	313		335		327		331	
1	19	19	1	1	8	8	5	5
2	3	6	1	2	1	2	1	2
3	1	3			1	3		
4	1	4						
*NR	19		19		19		19	
TOTAL	356	32	356	3	356	13	356	7

Total Suicide Deaths Reported for 2-year period = 55

Total Suicide Deaths Recorded by Texas Vital Statistics 1983-84 = 338

*Not Reporting

**Totals = Deaths X Number of School Districts Reporting

Table 13

SCHOOL SUPERINTENDENTS' ESTIMATES OF

SUICIDE **ATTEMPTS** BY **METHOD** (Fall, 1983 to Spring, 1985)

ATTEMPTS	FIREARMS AND EXPLOSIVES		POISONING		HANGING/STRANGULATION/ SUFFOCATION		ALL OTHER MEANS	
	ISDs	**TOTALS	ISDs	**TOTALS	ISDs	**TOTALS	ISDs	**TOTALS
0	329		310		330		301	
1	4	4	11	11	3	3	17	17
2			5	10			7	14
3			2	6			2	6
4			1	4			1	4
5			2	10			2	10
6			1	6				
7							1	7
8							1	8
9			1	9				
10	1	10			1	10		
11							1	11
100			1	100				
130							1	130
*NR	22		22		22		22	
TOTAL	356	14	356	156	356	13	356	207

Total Suicide Attempts Reported for 2-year Period = 390

Estimated Attempts in 2-year Reporting Period = 33,800

*Not Reporting

**Totals = Attempts X Number of School Districts Reporting

School superintendents reported that 38 of the 55 deaths were whites, 14 Hispanic, and 2 black. Of the 402 attempts reported, 323 were white, 48 Hispanic, 20 black, and 6 Asian (Tables 14 & 15).

Table 14

SCHOOL SUPERINTENDENTS' ESTIMATES' OF

SUICIDE **DEATHS** BY **ETHNIC GROUP**

	ASIAN		HISPANIC		BLACK		AMERICAN INDIAN		CAUCASIAN		OTHER	
DEATHS	ISDs	**TOTALS	ISDs	**TOTALS	ISDs	**TOTALS	ISDs	**TOTALS	ISDs	**TOTALS	ISDs	**TOTALS
0	337		326		335		337		310		336	
1			8	8	2	2			20	20	1	1
2			3	6					4	8		
3									2	6		
4									1	4		
*NR	19		19		19		19		19		19	
TOTAL	356	0	356	14	356	2	356	0	356	38	356	1

*Not Reporting

**Totals = Deaths X Number of School Districts Reporting

Total Suicide Deaths Reported for 2-year Period = 55

Total Suicide Deaths Reported by Texas Vital Statistics, 1983-84 = 338

Table 15

SCHOOL SUPERINTENDENTS' ESTIMATES OF

SUICIDE **ATTEMPTS** BY **ETHNIC GROUP**

	ASIAN		HISPANIC		BLACK		AMERICAN INDIAN		CAUCASIAN		OTHER	
ATTEMPTS	ISDs	**TOTALS	ISDs	**TOTALS	ISDs	**TOTALS	ISDs	**TOTALS	ISDs	**TOTALS	ISDs	**TOTALS
0	333		326		331		335		290		333	
1	1	1	3	3	1	1			21	21		
2			3	6	2	4			9	18	1	2
3									3	9	1	3
4			1	4					3	12		
5	1	5	1	5					4	20		
8									2	16		
12									1	12		
15					1	15			1	15		
30			1	30								
200									1	200		
*NR	21		21		21		21		21		21	
TOTAL	356	6	356	48	356	20	356	0	356	323	356	5

*Not Reporting

**Totals = Attempts X Number of School Districts Reporting

Total Suicide Attempts Reported for 2-year Period = 402

Estimated Attempts in These Ethnic Groups in 2-year Reporting Period = 33,800)

In summary, the majority (82%) of the reported fifty-five deaths occurred in the 15 to 19-year-old age group with males accounting for more than three-quarters of the suicides in that age group (78%). Of the 402 suicide attempts reported by age and gender, 145 were males and 257 were females. More than half of these attempts were found among the 15 to 19-year-old age group. Females in this age group accounted for almost three-fifths (59%) of the attempts. Firearms accounted for more than half the deaths reported (58%) while poisoning accounted for 39% of the attempts. A large number of attempts were suspected as car accidents in the "other method" category. In terms of the distribution of deaths and attempts by race, white youths predominated in both categories, 69% and 80% respectively. By age, race, and gender 15 to 19-year-old white males accounted for almost half (44%) of the deaths as reported by the school superintendents.

Suicide received the lowest ranking of the six issues listed (Figures 1 & 2). Forty-six percent of superintendents ranked "classroom management" as a leading topic for in-service training of their teachers; 25% ranked "drug and alcohol abuse" as a top priority.

Figure 1

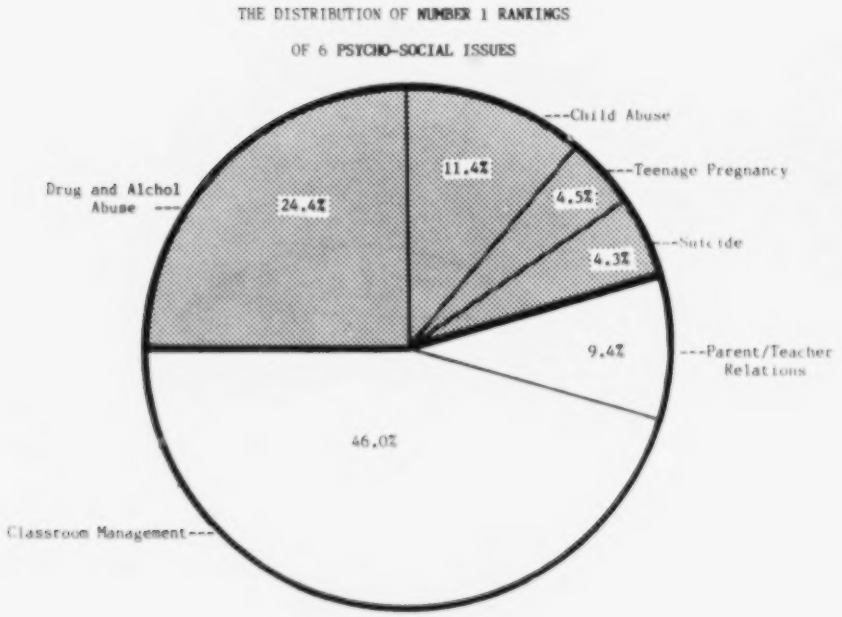
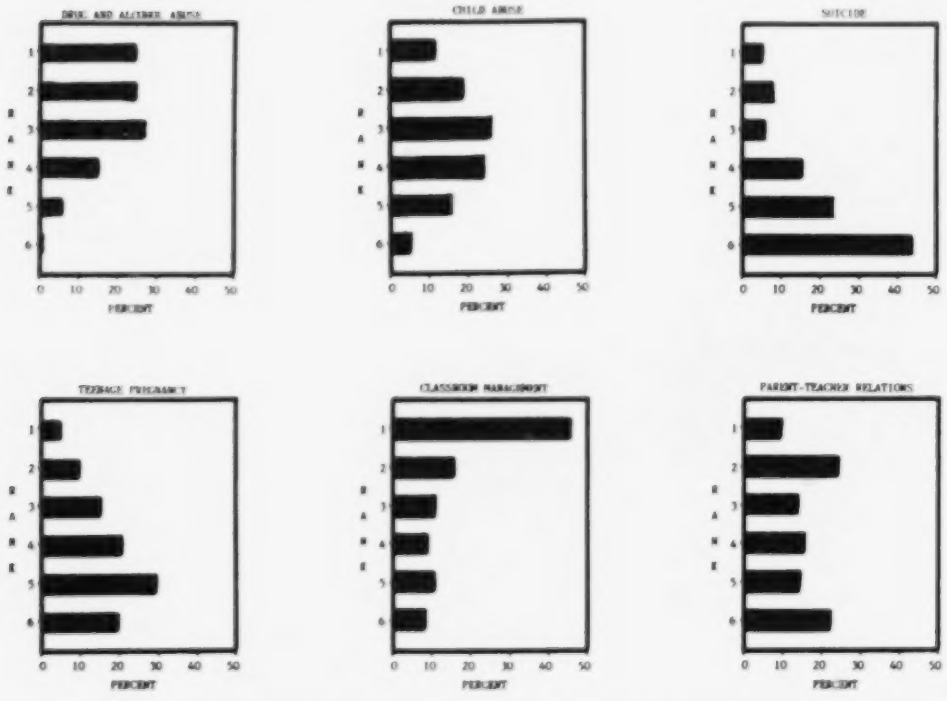


Figure 2



Forty-five percent of the superintendents ranked local mental health agencies as the group they believed should

provide top leadership in their communities' response to youth suicide with Suicide/Crisis Centers given top ranking by 27% (Figures 3 & 4).

Figure 3

THE DISTRIBUTION OF NUMBER 1 RANKINGS

OF 6 LEADERSHIP GROUPS

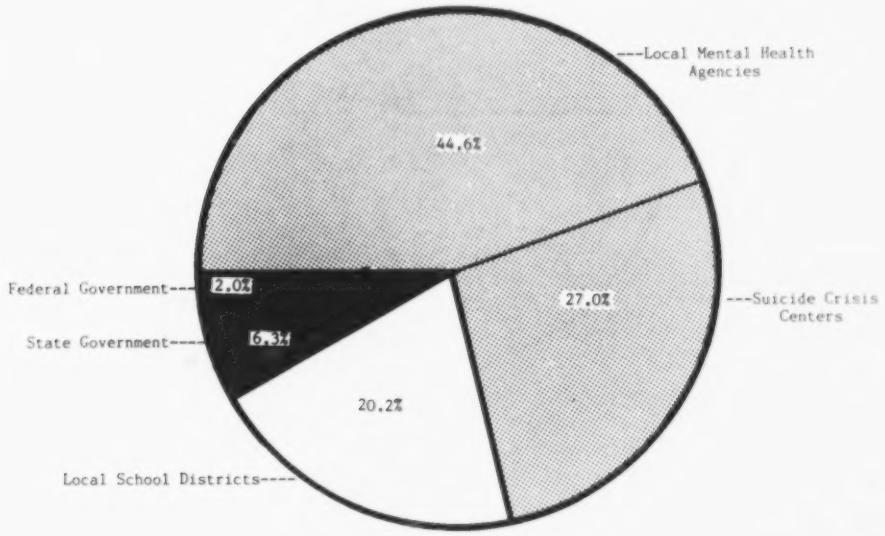
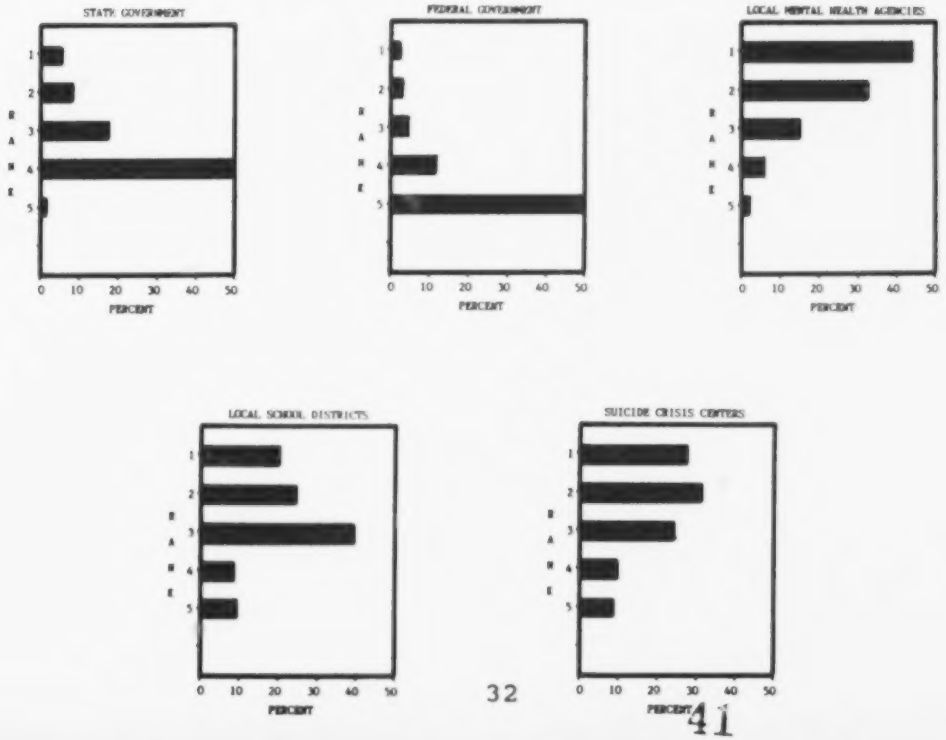


Figure 4

SCHOOL SUPERINTENDENTS' RANKING OF GROUPS WHICH SHOULD PROVIDE

COMMUNITY LEADERSHIP RESPONSE TO YOUTH SUICIDE



Individual leadership was divided almost equally between parents and local MH professionals, 39% and 36%, respectively (Figures 5 & 6).

Figure 5

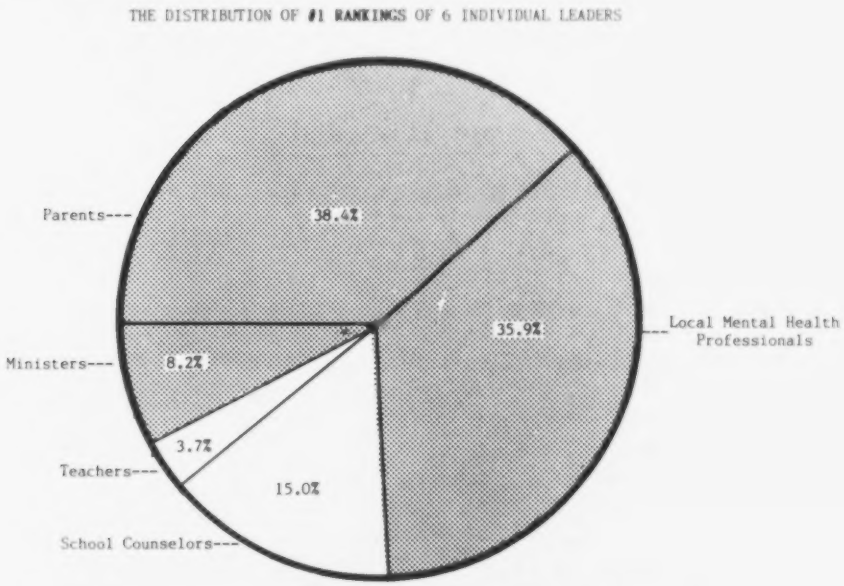
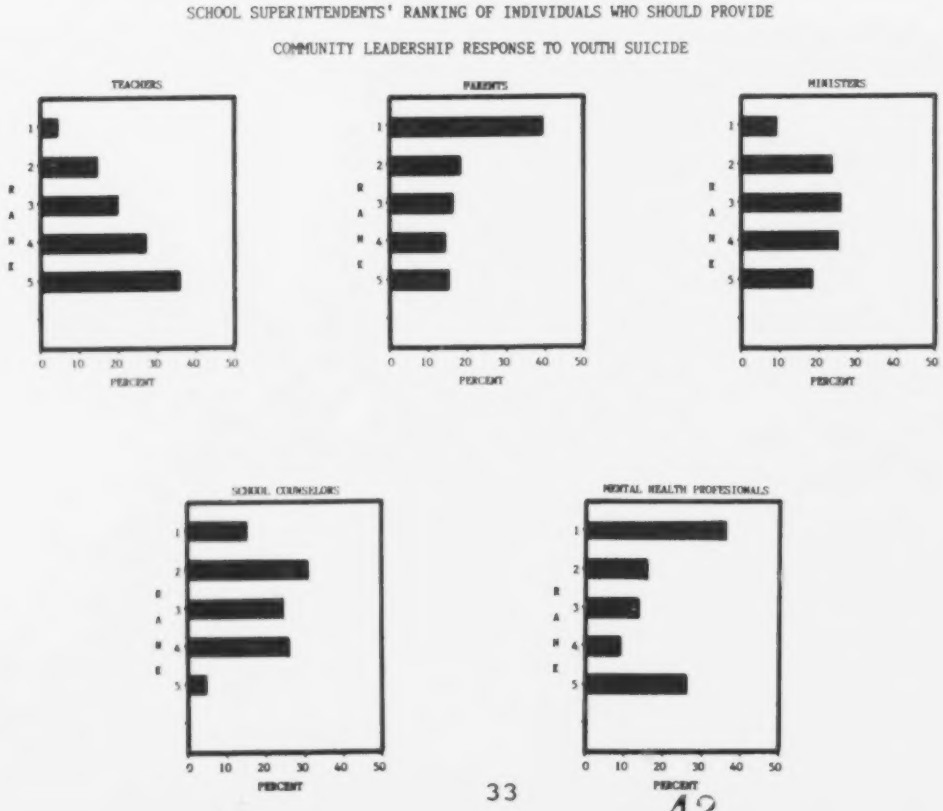


Figure 6



In summary, school superintendents responding to the survey did not find youth suicide as a particularly important topic to address in their in-service programs. Nor did they, as a group, find the school as an organization, or its teachers and school counselors as professionals, important in terms of a leadership response to the problem. External agencies and individuals were seen to be the groups and the professionals to take leadership roles in this area. Parents especially were viewed as possible leaders in a community's response--ahead of school counselors, teachers, and the clergy.

Four of the 356 superintendents indicated that their districts had written policies and procedures which addressed youth suicide and youth suicide attempts. One district had a policy which dealt with suicide attempts. Another sent a copy of a comprehensive broad-based district policy which covered prevention, intervention, and postvention. Currently there is one large metropolitan school district which is in the process of revising their procedures and has made a commitment to develop policies. This district formed a special committee in the fall of 1986 which includes school personnel as well as representatives from a variety of community agencies.

SURVEY OF MHMR CENTERS

Of the 32 Community MHMR Centers listed in the Texas Department of Mental Health and Mental Retardation Directory of Services, '86 (TDMHMR, 1986), 19 responded to the mail

and telephone questionnaire. Table 16 shows the percentage of those responding that had specific suicide related services available.

Table 16

SUICIDE RELATED SERVICES IN MHMR CENTERS

SERVICE	AVAILABILITY
Hotline	84%
Referrals	95%
Walk-in	84%
Assistance to Schools:	
In-service training programs	63%
Parent awareness programs	26%
Student awareness programs	42%
In-school counseling for surviving friends of suicide deaths	21%
In-school counseling for faculty after a suicide death	21%
Assistance in implementing suicide prevention programs	21%

The Community MHMR Centers, when asked to rank order the groups they believed should provide the leadership in their community's response to youth suicide, gave the following rankings: (1) local mental health agencies; (2) local school districts; (2) suicide crisis centers (ranked equal to ISDs); (4) state government; and, (5) federal government.

They were also asked to rank order the persons they believed should provide leadership in their community's response to youth suicide. Those rankings were: (1) local mental health professionals; (2) school counselors; (3) parents; (4) teachers; and, (5) ministers.

When asked to indicate their level of agreement or disagreement with a series of statements concerning youth

suicide services, all MHMR respondents indicated that schools should be involved in prevention and intervention. Ninety-five percent agreed or strongly agreed that schools should be involved in postvention.

Seventy-four percent of the respondents either disagreed or disagreed strongly with the statement that school counselors were qualified to provide suicide prevention services. Five percent agreed. Similarly, 74% disagreed or disagreed strongly with the statement that school counselors were qualified for providing intervention services. Fifty-eight percent disagreed or disagreed strongly that school counselors had the qualifications for providing suicide postvention services while 11% agreed.

Concerning school teachers, 68% of the community MHMR centers disagreed or disagreed strongly with the statement that teachers are able to identify youths at risk while 16% agreed. However, 95% agreed or agreed strongly that teachers "could be trained" to identify youths at risk for suicide.

Asked about their view of linking the schools and MHMR centers together to respond to youth suicide, 100% of the MHMR centers either agreed or agreed strongly that this should be done. Finally, 94% of the community MHMR centers said they believed that school districts should have a comprehensive, written policy for addressing youth suicide.

Two avenues of inquiry were pursued in this project. The first was concerned with the knowledge and beliefs of school superintendents in Texas. That is, what did they

know about the incidence of youth suicide deaths and attempts in their districts. Second, what were their opinions about suicide as a salient issue in young peoples lives and their beliefs about organizational and leadership responses to the problem. The second avenue of inquiry was the availability of mental health services and mental health professionals' opinions on the same issues as those presented to superintendents.

While school superintendents viewed the resolution of the problem of youth suicide as an activity that should mostly take place outside of the school organization, mental health professionals clearly considered the school to be an integral part of the community which could be and should be involved in the process. The issue separating the two groups would appear to be the "training" provision.

Finally, while an overwhelming number of the respondents did not have written policies and procedures for youth suicide, community mental health professionals clearly believed that these policies and procedures are essential.

DISCUSSION

Deaths are not officially recorded by school districts in Texas. Therefore, a direct comparison of the incidence reported by the school superintendents and the incidence recorded by the Texas Bureau of Vital Statistics (BVS) was not possible. When adjustments were made for the survey response rate, however, and comparisons were made between

the adjusted incidence reported and BVS figures, the proportion of youth suicide deaths reported by the superintendents underrepresents BVS records considerably (Figure 7). When estimates of attempts in relation to deaths were made using a 100:1 ratio, once again superintendents appear to be unaware of the extent of the problem (Figure 8). Figure 9 demonstrates graphically this discrepancy for the problem in the 15 to 19-year-old age group.

The results obtained in this project, however, are in agreement with views held by professionals concerning the general public's lack of knowledge about the incidence of youth suicide deaths and attempts.

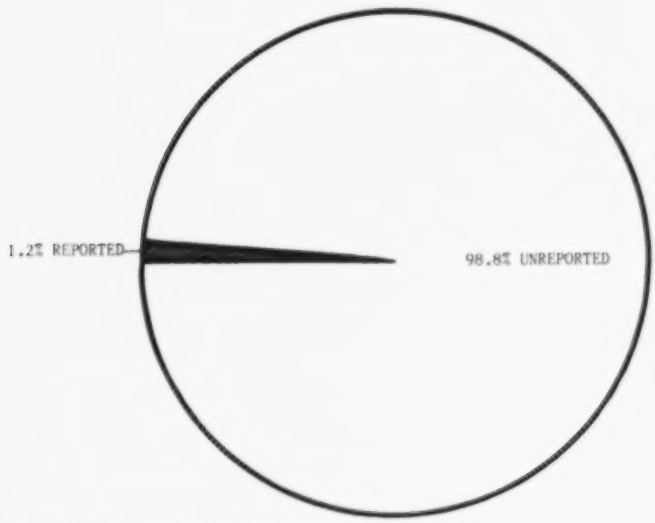
Figure 7

PROPORTION OF YOUTH SUICIDE DEATHS IN TEXAS REPORTED BY SCHOOL SUPERINTENDENTS

*Texas Vital Statistics, 1983-84

Figure 8

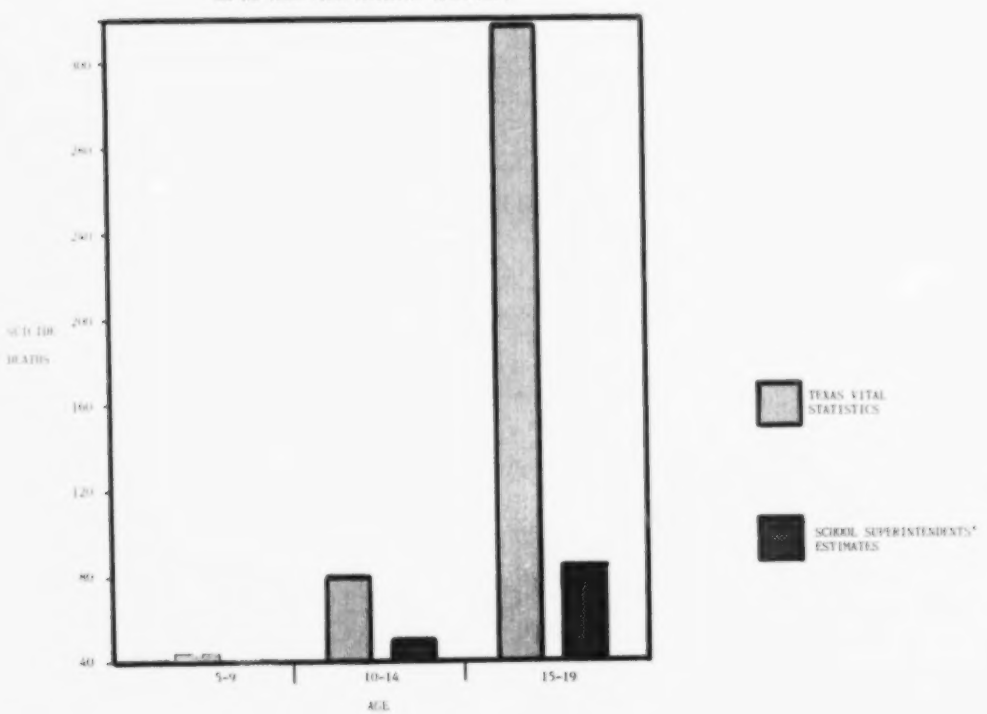
PROPORTION OF YOUTH SUICIDE ATTEMPTS IN TEXAS REPORTED BY SCHOOL SUPERINTENDENTS



*Estimates of attempts in relation to deaths varying from 50-120 attempts for every death (Jacobsiner, 1960, 1965; Tuckman and Connon, 1962). This chart reflects 100 attempts for every suicide death among youth ages 5-19 in Texas.

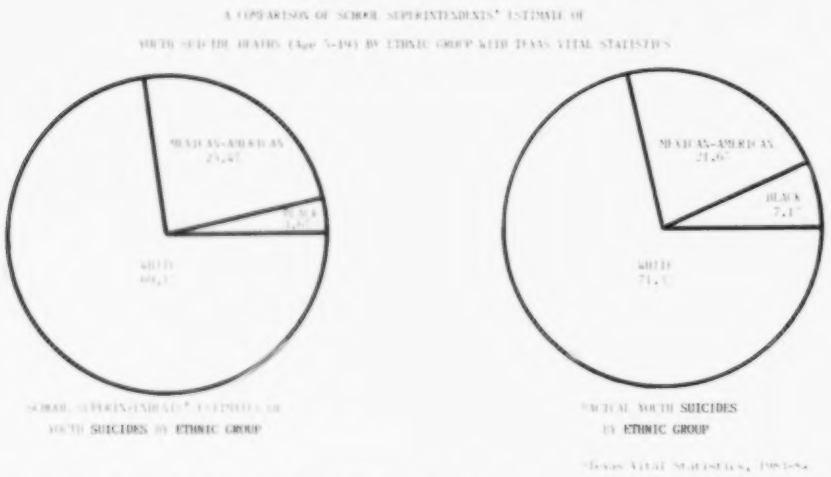
Figure 9

A COMPARISON OF SCHOOL SUPERINTENDENTS' ESTIMATES OF SUICIDE DEATHS BY AGE (Fall, 1985 to Spring, 1985) AND THE TEXAS VITAL STATISTICS (1983-1984)



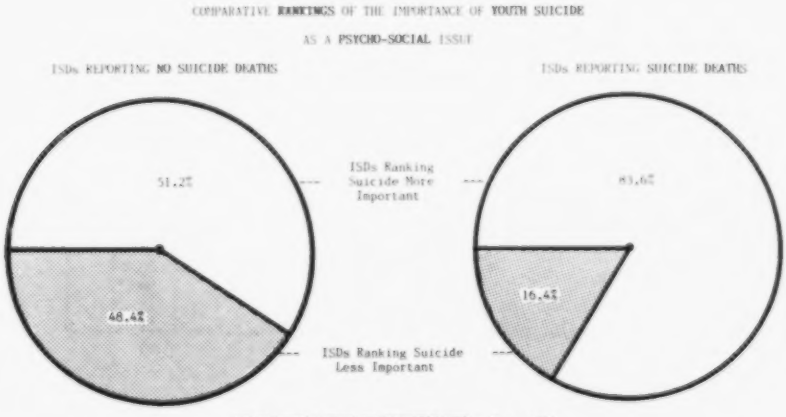
In contrast, school superintendents appear to have a more accurate estimation of the distribution of suicide attempts and deaths by race (Figure 10).

Figure 10



When a school district has had an experience of a youth suicide attempt or death, then the views of the administrator appear to change significantly. The need for in-service training for teachers becomes more important. Figure 11 demonstrates this change of view in the case of suicide deaths. A similar increase in perceived need for teacher in-service was found at the $p<.0001$ level of significance in the case of attempts.

Figure 11



When school superintendents have had the experience of a youth suicide death in their district, they view mental health professionals as being much more important in providing leadership (Figure 12). There is an interesting contrast, though, when the experience is that of youth suicide attempt. In this case, the administrators view school counselors as more important (Figure 13).

Figure 12

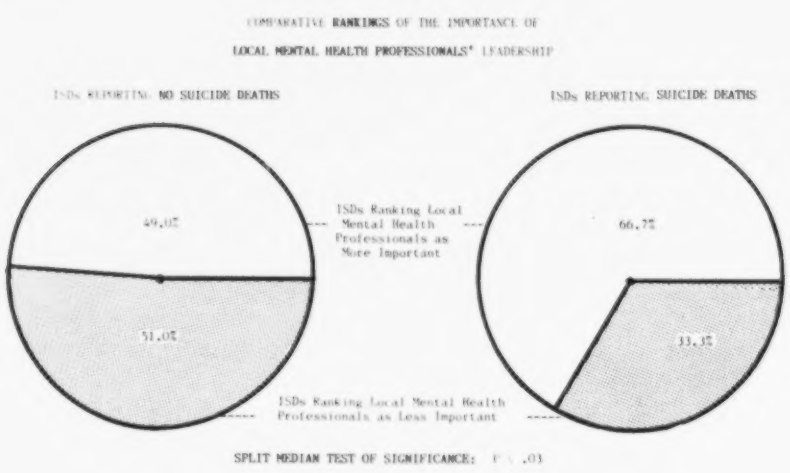
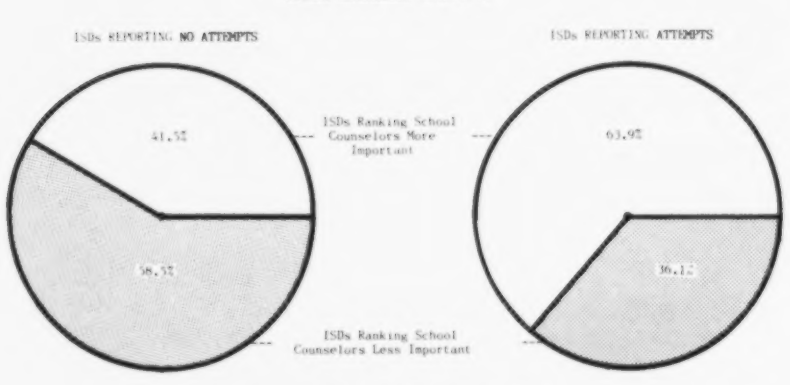

COMPARATIVE RANKINGS OF THE IMPORTANCE OF
LOCAL MENTAL HEALTH PROFESSIONALS' LEADERSHIP
ISDs REPORTING NO SUICIDE DEATHS
ISDs REPORTING SUICIDE DEATHS
49.0%
51.0%
66.7%
33.3%
ISDs Ranking Local Mental Health Professionals as More Important
ISDs Ranking Local Mental Health Professionals as Less Important
SPLIT MEDIAN TEST OF SIGNIFICANCE:

Figure 13



Suicidologists, epidemiologists, and the mental health community have provided considerable cumulative evidence that young people 15 to 19 years old constitute a particularly vulnerable group in terms of suicide ideation, attempts, and deaths. As a result valuable professional attention and information which presumably could provide direction to the education community appears to be available. How that expertise can be shared will be problematic if each professional community sees the other as having the principal leadership responsibility for dealing with the problem.

When mental health professionals were given the opportunity to voice their opinions about what might constitute the most effective method(s) for combatting youth suicide, their answers support this need to involve school communities. A content analysis of their comments provided a number of contextual findings which center on the themes of "linkages" and "professional training for teachers and school counselors." The following comments provide an illustration of these themes:

> Mandate school districts to train teachers and counselors; parent education sessions; identify major crises youths encounter and have groups to teach alternative ways to cope with stress; and establish suicide centers for youth.
>
> Training and education of school staff persons; also educational workshop for parents.
>
> It's an educational process. Teachers, counselors, and students need to know the signs of depression and those leading up to youth suicide.
>
> Train the school staff. Provide them with consultants to sensitize them to spot depression

and to intervene or to bring in a consultant.

Have a strong mental health association with education linkages.

A direct school/MHMR link; education to the lay population.

A similar analysis of the comments made by the school superintendents on the role of the school system provided a second set of contextual findings which center on the following themes:

1. This is not a problem.

   "Most kids I talk to never mention suicide."

2. This is not the school's problem.

   "HB 72 says...return to the basics."

   "I am not sure it's the schools' responsibility."

3. The school needs to provide education and information.

   "School is the best place to get the necessary information."

   "We are able to help students through our own counselors."

4. Schools need help to deal with this problem in terms of training their personnel.

   "I think all school personnel should have in-service in the causes, recognition of symptoms and treatment."

5. School personnel want to know about the signs they should be looking for in a suicidal student.

   "I believe it is the responsibility of the school to help with identification and prevention of possible suicide attempts."

School administrators appear, from their comments, to be somewhat divided about whether or not the school has any role at all. Although very few comments were made in terms

of linkages with the mental health professional community, the "need for training" issue appeared throughout the comments particularly in terms of intervention.

Summary

This project investigated the extent to which school districts in Texas maintained written policies which should be followed in the event of youth suicide deaths or attempts. The results of this study suggest that few school districts have such policies. Thus, the probability is that procedures for prevention, intervention, and postvention activities lack both internal planning and external networking with community agencies. The results from this survey indicate that there are three possible explanations for this state of affairs. The first may be that the lack of awareness of the problem makes the effort required to produce such policies appear unnecessary. The second may be that school administrators view the responsibility for management and treatment to lie outside the school, i.e. with the community mental health agencies. The third, and more likely explanation, is that until faced with this particular crisis with its attendant publicity, administrators are simply unaware of possible components for these policies. They are only then painfully aware of the need for careful preparation before a youth suicide occurs. Perhaps they also believe, at the time, that the event is unlikely to happen again!

Careful preparation and planning would help to design

policies which could address prevention, intervention, and postvention. The prevention component would consider the emotional developmental needs of children and their families. The intervention component would devise a well-defined system for each district in which connections to trained crisis intervention professionals would be made explicit and easily understandable by both students and adults. This system would also emphasize the development of linkages at the local level prior to the implementation so that any barriers to seeking help could be identified and resolved. Finally a postvention policy would recognize that for every youngster who suicides there remains behind a group of survivors: friends, families, and teachers. These are people who will also be in need of services and support at a time of untold pain and turmoil. By addressing the postvention policy issue the school districts would also be understanding an important prevention principle.

LEGISLATIVE ACTIONS

Youth Suicide Prevention Month

Joint Resolution 53 of the United States Congress proclaimed June of 1985 to be designated as "Youth Suicide Prevention Month." Five considerations substantiated the need for such recognition. These included the increase in reported suicide rate for youth from 1965 through 1985, the large numbers of suicide attempts, the impact of youth suicide on the nation's future and our inescapable societal responsibility for the resolution of this problem. The

wording of the resolution reflects a growing recognition that "youth suicide is a national problem which can only be solved through the combined efforts of individuals, families, communities, organizations, and government to educate society."

State Legislative Action

California. Within the last three years, five states have developed legislative plans to constructively address the problem. The first state legislation in the country designed to prevent youth suicide and also give help to potential suicide victims was California's Senate Bill #947 (passed 1983 and operative July 1, 1984). The California Youth Suicide Prevention School Program mandated the establishment of local programs in two counties, San Mateo (Northern California) and Los Angeles (Southern California). These local projects established model school programs for the prevention of youth suicide. Suicide prevention and crisis centers located in San Mateo and Los Angeles then served as coordinating centers for the planning and development of a statewide program for school and community youth suicide prevention efforts.

California recognized that county suicide prevention and crisis centers had already established a successful record in terms of prevention, intervention, and postvention, and therefore these centers were best suited to the task at hand. The state legislature placed emphasis on capitalizing on the available expertise creating

cooperative-joint ventures between the agencies and educational programs. The two demonstration projects in Los Angeles and San Mateo Counties were scheduled for development in three phases over a 3-year period. During the initial year, programs were planned and developed with implementation during the second year. An evaluation and technical report was to be delivered to the State Department of Education, the legislature, and the governor on or before January, 1987.

Youth suicide prevention projects could consist of both in-school classroom instruction and non-classroom school and community alternative programs. Teacher training is a third and vital component of the program and completes the overall project. The designated responsibilities of the California State Department of Education included interagency cooperation with county boards, the establishment of procedures for the collection and dissemination of project data, and the submission of an annual report to the state legislature.

The California budget for education allocates $315,000 for the program with $300,000 designated for local assistance and $15,000 for departmental operations. Drakulich, a representative of the California State Superintendent of Schools and State Department of Education described this program as "one of the most needed programs mandated by [the] state legislature" (Subcommittee on Human Services Briefing before Tom Lantos [R-CA], 1984). Critical to the success of California's effort appears to have been

the utilization of local programs which had already demonstrated significant effectiveness in increasing the identification and referral of high risk students.

Wisconsin. The Wisconsin Bill of 1985 contained five specific directions for the provision of assistance to schools for suicide prevention programs. This bill directed the Department of Public Instruction to conduct training programs for the staff of both private and public schools. Second, an advisory council was created to provide fellowship grants supporting advanced training in suicide prevention. Third, and in similar vein to California's requirements, funding was provided to support demonstration projects carried out by public school districts. Fourth, each school board was made responsible for instruction which would be designed to give pupils decision-making training as well as instruction in the probable causes and signs of suicidal tendencies and the relationship between suicide and alcohol/drug abuse. Pupils were to receive directions on available community youth suicide prevention services. Finally, the bill directed that instruction must be designed to promote pupils' positive emotional development as a safeguard against suicide.

Alabama. In the same year (1985), the Alabama Youth Emotional Guidance and Suicide Prevention Act (State Bill H284) provided for a network of cooperative endeavors among the Departments of Education, Mental Health, Pensions and Security, Youth Services, and Law Enforcement in the

identification, intervention, and prevention of youth suicide. A major component and emphasis for the Alabama statewide plan was to be the cooperation between state and local agencies.

Community mental health centers, school boards, advocacy committees, parent/teacher associations, law enforcement, and the courts provided input. The Department of Education and the Rehabilitation and Crippled Children's Services coordinated the information and presented the plan to the Speaker of the House of Representatives, the President of the Senate, and the Governor of the state. Guidelines for the development of the plan included the establishment of an interprogram task force whose major task was to provide an analysis and summary of detailed local plans thus completing a statewide perspective.

District local task forces directed by district administrators were asked to develop the district local plans of action. The service districts of the Departments of Health, Mental Health, and Rehabilitation and Crippled Children were designated as local areas. Local task forces prepared detailed written statements reporting their operating procedures, purpose, responsibilities, and methods devised to meet these responsibilities. In addition, specific information was developed to describe the districts' plan of action including the following:

a. Documentation of the magnitude of the problems of youth suicide in its geographical areas.

b. A description of programs currently serving suicidal or emotionally upset youth and their

families and of programs for the prevention of youth suicide including information on their impact, cost-effectiveness, and sources of funding.

c. A continuum of programs and services necessary for a comprehensive approach to the prevention of youth suicide as well as a brief description of such programs and services.

d. A description, documentation, and priority ranking of local needs related to youth suicide prevention based upon the continuum of programs and services.

e. A plan for steps to be taken in meeting identified needs including the rapid coordination and integration of services, and the avoidance of unnecessary duplication and cost.

f. A plan for alternative funding strategies for meeting needs through the reallocation of existing resources, utilization of volunteers, contracting with local universities for services, and local government or private agency funding.

g. A description of barriers to the accomplishment of a comprehensive approach to the prevention of youth suicide.

h. Recommendations for changes that can be accomplished only at the state program level or by legislative action. The district local plan of action to be submitted to the interprogram task force by October 1, 1985.

The Alabama legislation included a comprehensive description of "student services" which are to be made available to all pupils including those in the vocational technical centers. Every school in each district must maintain a written plan of student services developed by the principal, staff members, and a school advisory committee. A copy of the plan is submitted to the superintendent and school board annually. In addition to guidance, psychological, social work, and placement services, the plan

provides for the distribution of a suicide prevention public awareness plan.

By 1987, each person holding either a provisional or regular teaching certificate will be required by the Alabama Youth Educational Guidance and Suicide Prevention Act to formally demonstrate the ability

> to recognize signs of severe emotional distress in students and techniques of crisis intervention with emphasis on suicide prevention and positive emotional guidance or development.

Curriculum changes were recommended at the ninth and tenth grade levels in terms of life management skills training although no mention is made of what these special skills may be!

Other provisions of the Alabama Act included the training required for teacher certification and additional training for other appropriate public and private agency staffs.

Florida. A state plan for the prevention of youth suicide in Florida was established in 1984 as the Florida Youth Emotional Development and Suicide Prevention Act. This act also emphasizes cooperation between educational programs and community suicide and crisis centers.

The testimony of two parent advocate task force members, appearing as it does in the Florida state plan, highlights the deep pain, hurt, and anger of survivors of suicide. Their recommendations reflect the growing concerns of parents over the quality of educational programs and the qualifications and performances of classroom teachers.

Their emphasis on and warnings against environmental and system factors, their stress on the recognition of parental responsiblities, and their plea for improved communication between schools and families reflect a willingness to participate actively in the implementation of suicide prevention measures in their state. Moreover, their opposition to programs which teach decision-making skills or employ values clarification techniques reflects their fears that this type of affective educational strategy will undermine their parental authority and create the type of alienated, confused, and rebellious student who, they suggest, is then at risk. Thus, in Florida parental signature of consent must be given before any student is exposed to suicide prevention programs. There are several indications, however, that the state reacted too quickly to these parental concerns resulting in ineffective legislation (personal communication from Florida Mental Health Professional). First, Florida's helping professionals have been expected to finance their crisis intervention programs with existing strained resources. Second, district reports of available services and assessments of local situations were drafted too rapidly resulting in an inadequate state report. Finally, the various departments involved in the provision of services -- Education, Law Enforcement, Health and Rehabilitation -- appear to be unclear regarding their individual responsilibities. Clearly the implication for any state undertaking the design of youth suicide legislation should be the enhancement of their efforts

through the detailed examination of model legislation from other states. For example, California's funded plan required three years of development, implementation and evaluation.

New Jersey. The New Jersey Youth Suicide Prevention Program (1985) was established in the state's Department of Human Services and is administered by community mental health providers in cooperation with local boards of education. Three programs were selected from a number of proposals and initiated in North, Central, and South New Jersey. Each is directed by a local community mental health center provider with two or more local boards of education. The Commissioner of Human Services, in consultation with the Commissioner of Education, had established guidelines to be followed by these programs. Once again there is an emphasis that the goal of this leadership should be to foster cooperation between local boards of education and community mental health services providers.

In addition, a Youth Suicide Prevention Advisory Council was formed with ten members representing a broad based constituency (commissioners, project directors, suicide specialists, school board members, school administrators, and secondary school classroom teachers). This advisory council is responsible for the assessment of cost and the most effective and efficient method for establishing new programs. Second, the council disseminates information on youth suicide prevention programs statewide.

Third, the council provides advice and information about youth suicide to both commissioners. Finally, within 18 months of the date of the act, the advisory council reports on all of these activities to both the governor and the legislature. Recommendations are expected to include means whereby programs can be appropriately extended statewide.

The New Jersey programs focus on three components: classroom instruction and materials, non-classroom activities (which include a 24-hour hotline service), and training programs for classroom professionals. Students are taught factual information including signs of suicide intent and the relationship between adolescent suicide and drug/alcohol abuse. Information about community services available for crisis intervention is also given with this classroom material. The 24-hour hotline is staffed by trained professional counselors. Community programs include parent education, survivor support, and crisis intervention services.

Federal Legislative Activity

A number of public hearings have been held by the federal government during the last three years. The U.S. House of Representatives Select Committee on Children, Youth and Families heard testimony from three panels of experts in October, 1983. This hearing, entitled "Teenagers in Crisis: Issues and Programs," highlighted teenage suicide as a major concern. A year later, the U.S. Senate Subcommittee on Juvenile Justice of the Committee on the Judiciary in the U.S. Senate held another hearing, entitled "Teenage

Suicide," to gain some perspective on the factors that may lead to teenage suicide and determine what preventive measures may be effective. Witnesses included H. Ownby, District Attorney from Collin County, Texas, and Alan L. Berman, Ph.D., president of the American Association of Suicidology (AAS), and other noted experts in the field of adolescent suicide. In 1985, this same subcommittee held yet another hearing, this time entitled "The Federal Role in Addressing the Tragedy of Youth Suicide." The focus was on the adequacy of current federal research and prevention efforts and the role of the Office of Juvenile Justice and Delinquency Prevention in the area of youth suicide. This time the list of witnesses included Larry B. Silver, M.D., from the National Institute of Mental Health (NIMH), Dr. Susan Blumenthal, chief of the Suicide Research Unit at NIMH, Dr. Pamela Cantor, president of AAS, and Charlotte P. Ross, co-chairperson, National Committee for Youth Suicide Prevention and director of the Youth Suicide and Crisis Prevention Center of San Mateo County, California.

The Youth Suicide Prevention Act passed the House of Representatives on July 14, 1986, and was then referred to the Senate Subcommittee on Education, Arts, and Humanities. The bill establishes a grant program to assist local education agencies and private non-profit organizations to establish and operate youth suicide prevention programs. Grants will be used to:

a) Increase awareness of youth suicide among families, students, and community teachers;

b) Train school personnel and community leaders in prevention strategies;

c) Coordinate youth suicide efforts with government alcohol and substance abuse programs;

d) Utilize community resources in development and implementation of youth suicide prevention programs;

e) Cooperate with other appropriate agencies and organizations in youth suicide prevention.
(Newslink, 12 (3), 1986)

Award monies outlined in prior drafts of the bill were placed at a total of $6,000,000 to be made available for each fiscal year. In the final bill, however, any grant made by the secretary under this act may not exceed $100,000 in any fiscal year, while only $1,000,000 was to be made available for the 1987 fiscal year. Any projects funded by the federal government must have adequate evaluation procedures and be prepared for national dissemination.

This federal involvement has been designed to ensure that programs are of "high quality, well designed, responsibly implemented, and coordinated with existing programs and services" (Youth Suicide Prevention Act, 1986, p. 5). School counselors and school social workers are recognized as having key roles to play in a successful prevention/intervention program. "The school counselor has much more responsibility than the verification of graduation requirements" (YSPA, 1986, p. 6)! This recognition of the expertise of these two professions requires school districts to reexamine the recognition that they have grudgingly given to the affective and psychological contributions of these

"other" school personnel. The YSPA emphasizes that additional specialized training should be provided to school counselors and school social workers as well as teachers and administrators.

Nineteen eighty six has also been a landmark year at the national level for key professionals as they gathered together on at least four occasions to provide leadership in the coordination and dissemination of prevention and intervention programs and research.* In April, the American Association of Suicidology Annual Conference summarized key issues in suicide prevention particularly among school-age youth. In May, July, and November, three national conferences sponsored by the U.S. Department of Health and Human Services brought together experts in the fields of epidemiology, psychosocial behavior, and biology. Their goal was to gather together what is currently known about youth suicide and the wide range of interventions used in prevention. Practitioners and theoreticians in suicidology, mental health, education, social work, and community-based service programs discussed multidisciplinary findings in prevention and intervention. Finally, recommendations for research, education, and services were developed for both the public and private sectors of communities.

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* We were unable to participate in these key conferences. The preliminary recommendations made by DHHS Task Force on Youth Suicide are unavailable at the present time. Their release in 1987 should provide critical information for the professional community.

Texas Legislative Action

Texas' experience with cluster suicide in Clear Lake, Houston, and Plano has been dramatic and produced considerable media attention at both state and national levels. The Texas Family Code Section 35.03 was amended in September, 1985 to include references to the consent of minors. The addition of subsection (g) to section 35.03 ensures that minors can receive help without consent of their parents or guardians when the problem is sexual abuse, physical abuse, or suicide. Professionals can also now advise parents or guardians with or without the minor's consent about the treatment being given or needed for these three areas. Further, the written statement of a minor can be accepted by professionals as sufficient consent to treatment provided that that consent has not already been refused by law. However, this legislation appears to be minimal in terms of the role that could be and should be played by the state in cooperation with the various public and private agencies. If prevention is to become a state-wide priority, then clearly Texas can profit from the strategies adopted through formal legislative process in other states as well as those recommended at the federal level.

RECOMMENDATIONS

The findings of this project demonstrate the need for legislative action in the development and implementation of written school policies and procedures to address effective

prevention, intervention, and postvention activities for youth suicide in Texas. Several salient factors emerge from the legislation reviewed, the project results, and the survey of programs and literature undertaken during this project.

1. Legislation should be devised to establish a three-stage process: development, implementation, and evaluation. During the initial developmental phase, information should be sought from those school districts that have already or are in the process of writing their policies, e.g. Dallas Independent School District and Cypress Fairbanks Public Schools, Houston. Also, at this stage, key resource clinicians and researchers in the state should be identified and contacted for their input. The recommendations from this report (pp. 62-63) can also be used to identify what schools must do as well as what they may do to identify, intervene, and deal with a potential or actual suicide event.

During the second phase, implementation, school boards would be required to implement, within the policy guidelines created by legislation, specific written policy for their school districts and provide training programs for both in-school personnel and community-based groups.

During the third phase, evaluation procedures should be carried out to determine whether the various programs and projects have been effective by assessment of personnel knowledge and skills as well as a multi-assessment of student adjustment (Cowen, Gesten, & Weissberg, 1980).

2. A training component should be carried out at both the pre-service and the in-service levels for administrators, teachers, and school guidance counselors. At all levels, the quality of coursework and workshops will ultimately depend on the qualifications of trainers. Trainers should be well qualified in the field of suicide and crisis intervention and have current relevant clinical experience. Ultimately, all teachers, administrators, and counselors would be required to have one 3-credit hour course which deals specifically with prevention, intervention, and postvention procedures and activities for youth suicide prior to certification.

3. Counselors should be allowed and expected to play a greater role in the pre-, inter-, and postvention suicide processes. N. L. Johnson, R-Connecticut, sums up the critical waste of counselor skills (Hearing before Select Committee on Children, Youth, and Families, 1983, p. 6):

> . . . we see the money that we are putting into counselors in public high schools is basically going to scheduling and academic counseling . . . [if we could] use them as vehicles for the kind of curriculum that you have found effective, we may be able, even within our existing resources, to do a very much better job.

Guidance counselors need to direct their efforts into providing developmental guidance services to enhance the prevention component of a suicide/crisis program. Their training and experience as teachers should be capitalized on and, as a result, young people can be trained in life skills activities such as communications and interpersonal skills,

choice-making and decision skills, and coping-with-"loss" skills. In addition, guidance counselors can develop peer counseling activities and advise school administrators about possible enhancement of school climate and the developmental emotional needs of young people.

4. There is a need for an emphasis on coordination and cooperation at state and local levels. This coordination/ cooperation component refers to the exchange of information about successful programs and access to some centralized resource which informs about "who" is doing "what" and "where" that is being done in the state. Our early efforts to access this information through a variety of bureaucratic agencies created confusion and frustration. We found that the highest quality of technical information was provided for us by the American Association of Suicidiology and the Dallas Suicide and Crisis Center.

5. Every effort should be made to educate the news media about the dangers of fictional programs about suicide. For example, during the fall and winter of 1984-85 a series of four such films was broadcast by the networks to "increase public awareness and acceptance of the problem of suicide"(Gould & Schaffer, 1986). Comstock (Austin MHMR Conference, 1986) suggests that media representatives will be receptive to information about responsible reporting when that is made available. Clearly, school districts need to have this information before being faced with this kind of emergency.

6. The funding that would be required by Texas youth

suicide prevention legislation could be assessed by reviewing the costs involved for other states, in particular California. Rapid implementation without appropriate funding could seriously inhibit the potential positive outcomes of any such legislation.

A Model for the Development, Implementation, and Evaluation of School Suicide Policies

A. State Advisory Committee and Leadership

Suicide and Crisis Centers accredited by the American Association of Suicidology (AAS) can provide leadership by electing representatives to serve on a state advisory committee. Their duties could include:

A1. liaison with a Department of Health and Human Services Task Force on Youth Suicide;

A2. assistance to other agencies to reach required AAS standards for accreditation so that the state has adequate service coverage for all regions;

A3. maintenance of records of school policies, procedures, and programs and provision of evaluation services;

A4. assistance to school districts in developing and implementing suicide/crisis procedures;

A5. liaison with Texas Education Agency for training and development strategies.

B. Schools

All schools should maintain and update written policy statements based on sound professional judgment. The lack of written crisis policy statements may require legislative action.

B1. Written crisis policy addressing youth suicide must have three components: prevention, intervention, and postvention activities.

B2. Written crisis policy addressing youth suicide should be translated into appropriate procedures at the school district level.

B3. All schools should evaluate their suicide procedures on a regular basis.

B4. All schools should maintain and update a quality referral sources directory.

C. Prevention: An education and training model with an emphasis on knowledge and skills

C1. School districts are required to identify children and adolescents at risk.

C2. School districts are required to provide quality in-service to administrators, teachers, and counselors.

C3. In-service education should be provided by suicide and crisis intervention specialists from AAS accredited agencies with relevant clinical experience.

C4. School districts are required to support their guidance and counseling services as vehicles for effective developmental mental health curriculum.

C5. School districts are required to provide parent organizations with workshops and presentations led by qualified trainers.

D. Intervention: An organized response model

D1. Schools and community agencies should establish a cooperative team procedure to be used for direct intervention.

D2. Community agencies should include police as well as mental health centers and private counseling and psychotherapy agencies.

D3. Crisis intervention teams should receive specific training in techniques for intervention.

D4. Schools should maintain and regularly update written referral sources for assistance in crisis intervention.

E. Postvention: Skilled supportive care

E1. Schools should have written post-suicide event procedures.

E2. Schools should recognize the need for post-

vention procedures following suicide by either a pupil or an adult.

E3. Schools should employ small group procedures led by administrators, teachers, and counselors to assist students emotionally following a suicide.

E4. Schools should have written procedures for media contacts which will be followed by their staff after a suicide.

E5. Schools should not memorialize a suicide pupil in an inappropriate manner, e.g. naming the year book after the suicide pupil.

SUMMARY

The need for the identification of effective concepts and practices in policies and procedures has become salient at both national and state levels. The growing incidence of youth suicide has provided a troubling reflection on the quality of the psychosocial development of a particular segment of our schools' population.

The problem of youth suicide has received increased attention from state and local public health authorities, from social service agencies, and from health care professionals. The uncertainties of school professionals could be alleviated through this project's research into effective policy recommendations for legislative consideration. Secondly, by reviewing current procedures and programs in prevention, intervention, and postvention, school districts can bring together for consideration a variety of separate efforts from which they can help to define, train, and implement practices which would beneficially impact their own communities.

CONCLUSIONS

An adequate plan is needed to ensure that recommendations for policy adoption such as these contained in this monograph be given full consideration prior to eventual implementation. Changes in school policy will only take place as a result of a complex process involving state legislators, professional organizations of educators, counselors, social workers, and mental health professionals. That process also involves the personal dedication and commitment of a variety of advocacy groups.

The simple recommendation that service delivery be centered on school districts with the public school as the focal institution served by and serving a network of community agencies implies a localization of leadership of a psychoeducational nature which, while enormously beneficial to our young people, may be an anathema to those in school district leadership roles. So be it. There are convincing arguments for specific policies and procedures in every school district and building. First, schools are second only to family in responsiblity for children's welfare. Children spend a considerable amount of time there and their attendance is mandated by law. Second, schools may find that they can be held liable in the event that they have either no policies or inadequate policies (Schools' Advocate, 1986). Third, schools provide a high ratio of professionals to student. With training, these professionals can be key resources in pre-, inter-, and

postvention activities. Fourth, schools already have an extensive formal and informal network of communication channels (Barrett, 1985). There is a considerable cost to all of us when youngsters attempt or complete suicide. It is not an exaggeration to say that such acts imply not only a sense of enormous psychological and emotional pain but also youngsters' despair over other means and other choices that might help alleviate some of their distress.

The research, reporting, and organization of this monograph is hardly likely to promote the policy recommendations contained therein. Our hope is that our complex network of associations and professionals will follow the example of the other states who have successfully implemented youth suicide prevention acts in the last three years by working with the state legislature to process and produce a plan which will be feasible for the State of Texas.

We acknowledge that the study and deliberation required by this topic can engender a sense of aversion and guilt in those who must take up this task. Fortunately, Texas already has highly qualified, talented, and sensitive individuals who can provide valuable expertise to our state's policy makers but, "in the last analysis, the prevention of suicide is everybody's business" (Shneidman, 1985, p. 238).

BIBILIOGRAPHY AND REFERENCES

Austin MHMR Conference (1986). Conference on youth suicide.

Baechler, J. (1979). Suicides. New York: Basic Book.

Barrett, T.C. (1985). Youth in crisis. Longmont, CO: Sopris West Inc.

Berkovitz, I. H. (1985). The role of schools in child adolescent and youth suicide prevention. In M. L. Peck, N. L. Farberow, & R. E. Litman (Eds.), Youth suicide. New York: Springer.

Berman, A. L. (1986). San Antonio Conference on Suicidal Behavior in Adolescents. Sponsored by Washington Psychological Center, P.C.

Berman, A. L., & Carroll, T. A. (1984). Adolescent suicide: A critical review. Death Education, 8, 53-64.

Borg, W. R., & Gall, M. D. (1979). Educational research (3rd ed.). New York: Longman.

Bourque, L. B., Kraus, J. F., & Cosand, B. J. (1983). Attributes of suicide in females. Suicide and Life-Threatening Behavior, 13 (2), 123-138.

Brown, S. L. (1985). Adolescents and family systems. In M. L. Peck, N. L. Farberow, & R. E. Litman (Eds.), Youth suicide. New York: Springer.

Center for Disease Control. (1986). Youth suicide in the United States, 1970-1980.

Chase, C. I. (1976). Elementary statistical procedures. New York: McGraw-Hill.

Chiles, J. A., Strosahl, K. D., McMurtray, L., & Linehan, M. M. (1985). Modeling effects on suicidal behavior. Journal of Nervous and Mental Disease, 173 (8), 477-481.

Cohen-Sandler, R., Berman, A. L., & King, R. A. (1982). Life stress and symptomatology: Determinants of suicidal behaviour in children. Journal of American Academy of Child Psychiatry, 21, 178-476.

Cowen, E. L., Gesten, E. L., & Weissberg, R. P. (1980). An integrated network of preventively oriented school-based mental health approaches. In R. H. Price & P. E. Politser (Eds.), Evaluation and action in the social environment. New York: Academic Press.

Craver, K. W. (1984). Adolescent suicide: An annotated bibliography for children and counselors. School Counselor, 31 (5), 467-476.

Farberow, N. L., & Shneidman, E. S. (1961). The cry for help. New York: McGraw-Hill Book Co.

Flynn, P. & McMahon, R. C. (1983). Indicators of depression and suicidal ideation among drug abusers. Psychological Reports, 52 (3), 784-786.

Frederick, C. J. (1985). An introduction and overview of youth suicide. In M. L. Peck, N. L. Farberow, & R. E. Litman (Eds.), Youth suicide. New York: Springer.

Friedman, R. C. (1984). Family history of illness in the seriously suicidal adolescent: A life cycle approach. American Journal of Orthopsychiatry, 54 (3), 390-397.

Gould, M. S. & Shaffer, D. (1986). The impact of suicide in television movies. New England Journal of Medicine, 315, 690-694.

Grob, M. C., Klein, A. & Eisen, S. V. (1983). The role of the high school professional in identifying and managing adolescent suicidal behavior. Journal of Youth and Adolescence, 12 (2), 163-173.

Horton, H., & Stack, S. (1984). The effect of television on national suicide rates. Journal of Social Psychology, 123 (1), 141-142.

Jacobziner, H. (1960). Attempted suicides in children. Journal of Pediatrics, 50, 579-525.

Jacobziner, H. (1965). Attempted suicide in adolescence. Journal of American Medical Association, 191 (1), 101-105.

Joan, P. (1986). Preventing teenage suicide: The living alternative handbook. New York: Human Sciences Press.

Kessler, R. C., & McRae, J. A. (1983). Trends in the relationship between sex and attempted suicide. Journal of Health and Social Behavior, 24 (2), 98-110.

Lajoie, S. P., & Shore, B. M. (1981). Three myths? The over-representation of the gifted among drop-outs, delinquents, and suicides. Gifted Child Quarterly, 25 (3), 138-143.

Lindblom, C. E. (1986). Who needs what social research for policy making. Knowledge, 7 (4), 345-365.

Lindegard, J. M. (1986). 17th annual survey of high achievers. Lake Forest, IL: Who's Who Among American High School Achievers.

Litman, R. E. (1963). Emergency response to potential suicide. Journal of Michigan Medical Society, 62, 68-72.

Mack, J. E. & Hickler, H. (1981). Viviene, the life and suicide of an adolescent girl. Boston: Little, Brown, & Co.

Maris, R. (1981). Pathways to suicide. Baltimore: The John Hopkins University Press.

Maris, R. (1985). The adolescent suicide problem. Suicide and Life Threatening Behavior, 15 (2), 91-109.

Matter, D. E., & Matter, R. M. (1984). Suicide among elementary school children. Elementary School Guidance and Counseling, 18 (4), 260-267.

McBrien, R. J. (1983). Are you thinking of killing yourself? Confronting students' suicidal thoughts School Counselor, 31 (1), 75-82.

McGuire, D. J., & Ely, M. (1984). Childhood suicide. Child Welfare, 63 (1), 17-26.

Motto, J. A. (1985). Treatment concerns in preventing youth suicide. In M. L. Peck, N. L. Farberow, & R. E. Litman (Eds.), Youth suicide. New York: Springer.

Motto, J. A., Heilbron, D. C., & Juster, R. P. (1985). Development of a clinical instrument to estimate suicide risk. American Journal of Psychiatry, 142 (6), 680-686.

Newslink, 10 (3), 1984, 1-2. American Association of Suicidology.

Newslink, 11 (2), 1985. American Association of Suicidology.

Newslink, 11 (4), 1985, 3. American Association of Suicidology.

Newslink, 12 (3), 1986. American Association of Suicidology.

Orbach, I. (1984). Personality characteristics, life circumstances, and dynamics of suicidal children. Death Education, 8, 37-52.

Peck, M. L., Farberow, N. L., & Litman, R. E. (Eds.). (1985). Youth suicide. New York: Springer.

Peck, H. S., Ford, A. B., & Rushforth, N. B. (1984). Suicide in the young. Boston: John Wright.

Phillips, W. C. (1983). Suicide education for residence staff: Identification, intervention, and referral. Journal of College Student Personnel, 24 (4), 376-378.

Phillips, D. P., & Carstensen, M. D. (1986). Clustering of teenage suicides after television news stories about suicide. The New England Journal of Medicine, 315 (11), 685-689.

Ray, L. Y., & Johnson, N. (1983). Adolescent suicide. Personnel and Guidance Journal, 62 (3), 131-135.

Ross, C. P. (1985). Teaching children the facts of life and death. In M. L. Peck, N. L. Farberow, & R. E. Litman (Eds.), Youth suicide. New York: Springer.

Schools' Advocate (1986). School districts can be sued for inadequate suicide prevention programs.

Shneidman, E. S. (1985). Definition of suicide. New York: John Wiley.

Shneidman, E. S. & Farberow, N. L. (Eds.). (1957). Clues to suicide. New York: McGraw-Hill Book Co.

Slaby, A. E., Lieb, J., & Tancredi, L. R. (1975). Handbook of psychiatric emergencies. New York: Medical Examination Publishing Co. Inc.

Smith, J. (1986). Coping with suicide: A resource book for teenagers and young adults. New York: The Rosen Publishing Group.

Smith, K., & Crawford, S. (1986). Suicidal behavior among "normal" high school students. Suicide and Life Threatening Behavior, 16 (3), 313-325.

Sudak, H. S., Ford, A. B. & Rushforth, N. B. (1984). Suicide in the young. Boston: John Wright.

Surviving: A handbook on teenage suicide prevention. ABC Theater Presentation, February 10, 1985.

Texas Department of Mental Health/Mental Retardation, Directory of Services, 1986.

Teen suicide: Alarming trend on the rise. (1985). NASW News, 30 (4), 7-8.

Tuckman, J., & Connon, H. E. (1962). Attempted suicide in adolescents. American Journal of Psychiatry, 119, 228-232.

U.S. Public Health Service. (1980). Promoting health/preventing disease: Objectives for the nation. Washington, D.C.: Government Printing Office.

Weisman, A. D. (1974). The realization of death. New York: Jason Aronson.

Youth Suicide Prevention Act (1986). 99th Congress, 2nd Session: H.R. 4650.

GOVERNMENT HEARINGS

Hearing before the Select Committee on Children, Youth and Families. House of Representatives. Ninety-eighth Congress. First Session. Washington, D. C., 1983.

Hearings before the Subcommittee on Juvenile Justice of the Committee on the Judiciary. United States Senate. Ninety-eighth Congress. Second Session. Teenage Suicide. Washington D.C., 1984.

A Briefing by the Subcommittee on Human Services of the Select Committee on Aging. House of Representatives. Ninety-eighth Congress. Second Session. Suicide and Suicide Prevention. San Francisco, CA, 1984.

Hearing before the Subcommittee on Juvenile Justice of the Committee on the Judiciary. United States Senate. Ninety-eighth Congress. First Session. Federal Role in Addressing the Tragedy of Youth Suicide. Washington, D.C., 1985.

Hearings before the Subcommittee on Elementary, Secondary, and Vocational Education of the Committee on Education and Labor. House of Representatives, Ninety-ninth Congress. First Session. Hearings on Youth Suicide Prevention Act of 1985. Washington, D.C. & Yonkers, NY, 1985.

APPENDICES

Appendix A

Selected excerpts from U.S. Congress, Hearing before the Select Committee on Children, Youth and Families, House of Representatives, Ninety-eighth Congress, First Session: Teenagers in Crisis: Issues and Programs (1983). (ERIC Document Reproduction Service No. ED248 455)

Testimony of Joan Lipsitz, director of the Center for Early Adolescence at the University of North Carolina at Chapel Hill:

> Adolescents do not have to be a drain on the resources of their communities. They can, instead, be resources for their communities. Adolescents, when invited and encouraged, provide companionship to the elderly, take care of younger children in day-care centers, construct community playgrounds, paint and weatherproof houses, serve as museum guides, do food shopping for the house-bound, shovel snow, clean parks. Their energy is proverbial.
>
> The question is only how the energy will out, whether it will be against us, against themselves, or on behalf of us all. Gwendolyn Brooks, in a poem called "Boy Breaking Glass," writes, "I shall create. If not a note, a hole. If not an overture, a desecration." Sometimes, we must turn to poets to hear what we will not learn from our children. (page 7)
>
> While we have scattered statistics, mental health figures are close to impossible to compile with accuracy, precision of definition, and age comparability. The Children's Defense Fund reports that two out of three seriously disturbed children and adolescents do not receive any services. Among the groups of troubled children least likely to receive appropriate and timely mental health care are "disturbed adolescents, especially those with serious or multiple problems and those who have been in hospital or may face hospital placement." Twenty percent of all people treated for depression are under 18 years of age. The President's Commission on Mental Health (1978) estimates that by age 18, 16% of the population will have needed mental health services. Figures for 3 to 15-year-olds are estimated to be anywhere from 5% to 15%.
>
> We do know that during the 1980s, teenagers have experienced the fastest growing suicide rate of any age group. Between 1960 and 1978 adolescent suicides among 15 to 19-year olds doubled for all but black females. The incidence of adolescent suicide is now two times greater for whites than blacks, three to four times greater

for boys than girls. (page 12)

One of the tasks of adolescence is exploring one's personal uniqueness and relatedness to other human beings. A paradox of adolescence is that one achieves this sense of individuality only when one sees oneself in terms of a larger social context. Identity is grounded in a world of others. Thus, adolescents are utterly dependent on others to reflect to them a positive, realistic image of themselves that they can integrate into their own inner image. They are also dependent on society to have a coherent set of purposes and expectations for them with which and against which they can define themselves. All too many adolescents fail to receive consistent, positive, realistic reflections of themselves from the adults on whom they are deeply dependent. Almost none receive the social coherence that would aid them in defining themselves, because society's role expectations for adolescents are conflicted and contradictory. (page 14)

We learned that adolescents "vote with their feet" by attending after-school programs in community centers, museums, libraries, schools, churches and synagogues, Boys Clubs, Girls Clubs, 4-H, and the like. We learned that they attend because there is an adult who knows and understands them. While a particular activity may be the "hook" that draws teenagers in, their loyalty to the program is dependent upon the sensitivity of an adult who has time to listen and to care. (page 20)

I had the privilege of going to the National Governors' Association meeting this year and one of the things that was very striking to me is that almost every resolution that was passed about children stopped at age 12. Those people who are really committed to working with adolescents are an endangered species, not because their commitment is waning, but because the social commitment to supporting their work is waning. (page 29)

Let me say that when you scratch beneath any of the disastrous statistics that we have, whether it be suicide, drug abuse, pregnancy, any of the statistics that show young people taking terrible risks with their own lives and the lives of others, including crime, right underneath is constantly the issue of low self-esteem.

The issue of self-esteem is not just something that we should be concerned about if we want to reduce the suicide rate or if we want to reduce the teenage pregnancy rate. It is something that we have to be concerned with across the board. (page 42)

Testimony of Kim Fields, co-star of Television Series, "Facts of Life":

> Kids are nearest to solutions, and can play a valuable role in reaching their peers with a message of faith and hope that life is worth living and can be better. Together kids and adults can find solutions to the many tragedies that place kids in crisis. (page 27)

Testimony of Mrs Fields, mother to Kim Fields:

> Let's bring in those power people, those influential kids that are in those schools, let's get them excited about the program. It is the outreach of kids to kids that is going to make that successful.
>
> That is a lot more effective than all of these forms and papers that nobody really gives a darn about.
>
> Kids are a valuable asset and a resource that are not being used, and every time you ever see some person that you give a lot of credit to for working so well with kids, and that is a dynamic person with young-person groups, it is always somebody that is not standing there in the limelight himself, but like this man here, letting the kids do it. (page 46)

Testimony of Judie Smith, program director, Dallas Suicide and Crisis Center, Texas:

> In spite of this aggressive programming, we fully expect that some day another young person will commit suicide in Plano. The anger and the fear will again be prevalent in a community that has high hopes for its young people and itself. More can be done. (page 56)

Testimony of Dr. Mary Griffin, medical director of the Irene Josselyn Clinic, Northfield, Illinois (book: A Cry for Help):

> As we explored the lives of the children who killed themselves we were struck by the frequent interruptions between the caretaker/parent and the infant in the first ten months. Recurrently, both from our post-suicidal reconstructions and from the popular and professional literature, we read and heard the details of interruptions and unpredictabilities between the infant and his

nurturing adult, with and from whom he must develop a basic sense of trust and acceptance. Basic to their relationship is the communication, first entirely physical, later interpersonal. Communication is first based on food and touch, on visual and auditory stimulation and response, on breathing together and caressing; finally, it moves into gesture and response, babbling and words, assertions and limitations; then finally it emerges into the uniquely human phenomenon of language and verbal communication.

Recurrently in our post-mortem reconstructions and from the literature, we noted the breakdown in communication which occurred in families just prior to the suicide. Repeatedly, parents exclaimed, "Why didn't he tell me it was so difficult?" or "What could have been all that bad that she had to kill herself?" Anyone who has reared adolescents knows the frustrations which are universal in trying to communicate with children in their teens. However, usually they talk with their friends; our suicided children did not do that either. The children who succeeded in killing themselves seemed to have more inhibition and more static in their communication than most adolescents. They were twice blocked: first in sharing with their families and secondly in opening up to their friends.

If the parents were out of communication with the potentially suicidal adolescent, who might be the person-option to catalyze emotional and verbal interchange not possible at home? The classroom teacher was elected without running. She or he could offer a different style, a different set, perhaps a more neutral interchange with the troubled adolescent. If the potential suiciding child was balanced on a narrow fulcrum, what might broaden the base? The answer was playful interchange with peers. Our action against suicide had taken form.

Buttressed by the school social workers, and aware of our support and encouragement, to say nothing of our gratitude, the teacher is urged to confront the troubled child with what she observes: depressed sounding poetry, a hopeless theme in a short story, declining application in studies, a sense of isolation. As the child begins to feel support to his narrow fulcrum and a holding environment eager to help, communication is restored in most cases. Years ago we had as policy that school personnel should withdraw when a child was suicidal; the condition was considered too ill to be seen at school. By following that policy we lost the greatest ally for the child, namely the person who had seen him every day and

often for hours at a time.

Similarly as mental health issues are added to classroom discussion in health, the suicidal student enters into at least a passive interchange with peers and, hopefully, the comfort which will permit a more active involvement with his peers. As he hears his classmates discuss death, suicide, drugs, separations, sex, loneliness, and fears of not being liked, the suicidal adolescent begins to play with his demons and his distortions, eventually sharing some of these with friends with whom he did not previously communicate. With the knowledge that adolescent pressures are universal, the potentially suicidal child becomes freer to choose constructive rather than self-destructive options.

Suicide is, after all, our most preventable disease of children. We have the responsibility to inject our medication, open communication into people touched by vulnerability. Might it have been possible that some of the suicides in Plano and in our area could have been avoided if we had been more aggressive in our insistence on medicating? I think so. (page 71)

Testimony of Eva Deykin, assistant professor, Harvard University, School of Public Health:

The first is our dearth of knowledge on the causes of self-destructive behavior among today's youth. To address this, we need more research. The federal government might wish to signal its commitment in this area by specifically allocating funds to study a range of potential risk factors. Secondly, the witnesses cast doubt on whether the traditional approaches to adolescent problems are really efficacious. Those teenagers who are willing to receive counseling or psychiatric therapy usually are able to profit from it, but for many, these traditional therapies carry an unwelcome stigma and are thus rejected. Thirdly, it was clear from all of the testimonies that the use of adolescents themselves as peer counselors has been largely overlooked. Teenagers are perhaps in the best position to identify youngsters in trouble and to offer a helping hand in a nonthreatening way. Adolescents are an extremely valuable and untapped resource if they can be given the appropriate training and backup. Here again, the federal government may wish to take an initiative by supporting the development of model curricula which could be incorporated into health education programs starting at an early level. (page 112)

APPENDIX B

Youth Suicide Legislation from Four States

NEW JERSEY - SENATE, No. 2005

a. Classroom instruction "or materials" designed to achieve the following objective: to teach students facts about adolescent suicide and how to recognize signs of suicidal tendencies; to inform students of available community services aimed at prevention of suicide; and to increase students' awareness of the relationship between adolescent suicide and drug and alcohol use.

b. Training programs for classroom teachers and other teaching staff members in suicide prevention.

c. Nonclassroom or community based programs such as a 24-hour "hotline" telephone service staffed by trained professional counselors, crisis intervention and postvention services, parent education programs, and programs for the families of suicide victims.

WISCONSIN - 1985 ASSEMBLY BILL 180

a. Develop and conduct training programs in suicide prevention for the professional staff of public and private schools. The programs shall include information on how to assist minors in the positive emotional development which will help prevent suicidal tendencies; the detection, by minors, school staff and parents, of conditions which indicate suicidal tendencies; the proper action to take when there is reason to believe that a minor has suicidal tendencies or is contemplating suicide; and the coordination of school suicide prevention and intervention programs and activities with the programs and activities of other state and local agencies. In developing the training programs, the department shall consult with the Department of Health and Social Services, the Council on Criminal Justice, local law enforcement agencies, local crisis intervention agencies and other state and community agencies that deal with suicide among minors. Persons other than public and private school professional staff may attend the training programs. The department may charge such persons a fee sufficient to cover the increased costs to the department of their participation in the programs.

CALIFORNIA - SENATE BILL No. 947

10215. The youth suicide prevention school programs established pursuant to Section 10210 shall plan, fund, and implement educational programs, which may include any of the following:

A. Classroom instruction designed to achieve any of the following objectives:
   1) Encourage sound decision making and promote ethical development.
   2) Increase pupils' awareness of the relationship between drug and alcohol use and youth suicide.
   3) Teach pupils to recognize signs of suicidal tendencies and other facts about youth suicide.
   4) Inform pupils of available community youth suicide prevention services.
   5) Enhance school climate and relationships between teachers, counselors, and pupils.
   6) Further cooperative efforts of school personnel and community youth suicide prevention program personnel.

B. Nonclassroom school or community-based alternative programs, including, but not limited to:
   1) Positive peer group programs.
   2) A 24-hour "hotline" telephone service, staffed by trained professional counselors.
   3) Programs to collect data on youth suicide attempts.
   4) Intervention and postvention services.
   5) Parent education and training programs.

C. Teacher training programs.

ALABAMA YOUTH EMOTIONAL GUIDANCE AND SUICIDE PREVENTION ACT (STATE BILL H284)

Section 11. A "student services program" is defined as a coordinated effort which shall include, but not be limited to:

(a) Guidance services, which shall include, but not be limited to, the availability of individual and group counseling to all students, orientation programs for new students at each level of education and for transferring students, consultation with parents, faculty, and out-of-school agencies concerning student problems and needs, utilization of student records and files, supervision of standardized testing and interpretation of results, the following up of early school dropouts and graduates, a school-initiated system of resources on which to base educational and vocational decision making, and educational and job placement.

(b) Psychological services, which shall include, but not be limited to, evaluation of students with learning or adjustment problems, evaluation of students in exceptional-child education programs, consultation and counseling with parents, students, and school personnel, a system for the early identification of learning potential and factors which affect the child's educational performance, a system of liaison and referrals, with resources available outside of the school, and written policies which assure ethical procedures in psychological activities.

(c) Visiting teacher and school social work services,

which shall include, but not be limited to, providing casework to assist in the prevention and remediation of problems of attendance, behavior, adjustment, and learning and serving as liaison between the home and school by making home visits and referring students and parents to appropriate school and community agencies for assistance.

(d) Occupational and placement services, which shall include, but not be limited to, the dissemination of career education information, placement services, and followup studies. Such followup studies may be conducted on a statistically valid random-sampling basis where appropriate and shall be stratified to reflect the appropriate vocational programs of students graduating from or leaving the public school system. The occupational and placement specialist shall serve as liaison between employers and the school. It shall be the responsibility of district placement personnel to make written recommendations to the superintendent for consideration by the district school board concerning areas of curriculum deficiency having an adverse effect on the employability of job candidates or progress in subsequent educational experiences. Further, district administrative personnel shall report to the school board concerning adjustments in program outcomes, curricula, and delivery of instruction as they are made with the use of placement and followup information.

(e) The distribution of a suicide prevention public awareness program developed for distribution by the interprogram task force established by the Departments of Health, Education, Rehabilitation and Crippled Children's Service, and Mental Health.

APPENDIX C

A Selection of Published and Unpublished Resources and Training Guides

1. American Association of Suicidology

   Merck, Sharp & Dohme, Suicide Prevention Training Manual.

2. Colorado

   Bebensee, B. A., & Pequette, J.R., Perspectives on Loss

3. Colorado

   Barrett,T.C.(1985),Youth in Crisis: Seeking solutions to destructive behavior. Longmont, CO: Sopris West.

4. Georgia

   Hannaford, M.J. (1983), The Joy of Sorrow

5. New Jersey

   South Bergen Mental Health Center, Inc., Adolescent Suicide Awareness Program (ASAP).

6. Rhode Island

   The Samaritans, Inc., The Teacher's Manual for the Prevention of Suicide Among Adolescents.

7. Texas

   Smith, J. (1984), Suicide Prevention. An Introduction to Crisis Intervention: A Curriculum for Adolescents. Dallas, TX: Suicide and Crisis Center.

APPENDIX D

CENTER FOR POLICY STUDIES' SURVEY OF TEXAS SCHOOL SUPERINTENDENTS: YOUTH SUICIDE

YOUTH SUICIDE AND THE ROLE OF THE SCHOOL SYSTEM

I. GENERAL INFORMATION

1. COUNTY CODE_____

2. DISTRICT CODE_____

II. SUICIDES AMONG SCHOOL AGE CHILDREN

Please indicate the number of school aged deaths, suicides, and attempted suicides you believe have taken place in your school district over the past 2 school years (i.e. Fall, 1983 to Spring, 1985).

1. TOTAL NUMBER

_____ DEATHS DUE TO ANY CAUSE

_____ SUICIDE DEATHS IDENTIFIED

_____ SUICIDE DEATHS SUSPECTED

_____ NON-LETHAL SUICIDE ATTEMPTS IDENTIFIED

_____ NON-LETHAL SUICIDE ATTEMPTS SUSPECTED

2. AGE OF VICTIMS

		Age		
	Sex	5-9	10-14	15-19
IDENTIFIED DEATHS	MALE			
	FEMALE			
IDENTIFIED ATTEMPTS	MALE			
	FEMALE			

3. ETHNICITY

	ASIAN	HISPANIC	BLACK	AMERICAN INDIAN	CAUCASIAN	OTHER
IDENTIFIED DEATHS						
IDENTIFIED ATTEMPTS						

4. METHOD

	FIREARMS & EXPLOSIVES	POISONING	HANGING, STRANGULATION, & SUFFOCATION	ALL OTHER MEANS
IDENTIFIED DEATHS				
IDENTIFIED ATTEMPTS				

III. SUICIDE POLICIES AND PROCEDURES IN YOUR SCHOOL DISTRICT

1. Please rank order the most important areas (in your view) of in-service training for teachers in the following psycho-social problem areas. (Rank from most important, #1, to sixth in importance, #6.)

   _____ Drug and alcohol abuse

   _____ Child abuse

   _____ Suicide

   _____ Teenage pregnancy

   _____ Classroom management and discipline

   _____ Parent-teacher relations

   Please specify any other area of great concern to you:_____

2. Please rank order the groups you believe should provide the leadership in your community's response to the tragedy of youth suicide. (Rank from most important, # 1, to fifth in importance, # 5)

   _____ State government

   _____ Federal governnent

   _____ Local mental health agencies

   _____ Local school districts

   _____ Suicide crisis centers

3. Please rank order the persons you believe should provide the leadership in your community's response to the tragedy of youth suicide. (Rank from most important, #1, to fifth in importance, # 5.)

_____ Teachers

_____ Parents

_____ Ministers

_____ School counselors

_____ Local mental health professionals

Specify other persons you believe should provide leadership:

_____

4. In your district, is there a written policy addressing

SUICIDE ATTEMPTS? Yes____ No____

SUICIDE DEATHS? Yes____ No____

****

NOTE: IF YOUR DISTRICT DOES NOT HAVE A WRITTEN STATEMENT OF SUICIDE POLICIES AND PROCEDURES, PLEASE SKIP QUESTIONS 5-8 AND GO ON TO # 9.

****

5. Would you be willing to send us a copy of your district's suicide policies and procedures (in response to a future request)?

Yes____ No____

6. If your district has written suicide procedures, check any or all of the following which are included in those procedures.

_____ Teacher in-service training on youth suicide.
_____ Student suicide awareness programs.
_____ Specific guidelines for schools to follow after suicide ATTEMPTS.
_____ Specific guidelines for schools to follow after suicide DEATHS.

7. According to your district's statement of procedures, who are school personnel to contact in the event of suicide attempts or deaths? (Please check all appropriate spaces.)

ATTEMPTS	DEATHS	
_____	_____	Psychologist / Psychiatrist
_____	_____	Professional Counselor
_____	_____	Physician
_____	_____	Crisis intervention center
_____	_____	Police or sheriff
_____	_____	Mental health center
_____	_____	School counselor
_____	_____	School supervisor
_____	_____	I. S. D. central office
_____	_____	Parents
_____	_____	Other (specify:_____)

8. Do your stated suicide procedures provide for any of the following activities after suicide ATTEMPTS or DEATHS? (Please check all appropriate spaces.)

ATTEMPTS	DEATHS	
_____	_____	Discussion with individual students
_____	_____	Class room discussion
_____	_____	General assembly on suicide
_____	_____	Counselor support for students
_____	_____	Counselor support for faculty
_____	_____	Counselor support for family of victim
_____	_____	Involvement by local mental health center
_____	_____	Involvement by local crisis intervention center

9. The name and address of the local mental health center your school district might call on for help in dealing with youth suicide is

NAME: _____

ADDRESS: _____

_____

If you have a specific contact person at the above center, his/her name is

_____

10. The name and address of the local crisis intervention center your district might call on for help in dealing with youth suicide is

NAME: _____

ADDRESS: _____

_____

If you have a specific contact person at the above center, his/her name is

_____

IV. YOUR THOUGHTS

Please feel free to provide any comments you wish to make about youth suicide and the role of the school system:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

If you would like information on the results of this study, check here: _____

THE CENTER FOR POLICY STUDIES WOULD LIKE TO THANK YOU FOR COMPLETING THIS SURVEY. YOUR ASSISTANCE WILL HELP US TO DEVELOP A COMPREHENSIVE VIEW OF THE CURRENT SITUATION IN THE STATE OF TEXAS.

APPENDIX E

CENTER FOR POLICY STUDIES' SURVEY OF DIRECTORS OF MENTAL HEALTH/MENTAL RETARDATION CENTERS: YOUTH SUICIDE

NAME_____ PHONE_____

ADDRESS_____

COUNTIES SERVED_____

I. FREQUENCY OF SUICIDES

What % of your services is related to: SUICIDE PREVENTION_____

SUICIDE INTERVENTION_____

SUICIDE POSTVENTION_____

How many cases related to suicide attempts does your staff handle per year?_____

How many cases related to suicide deaths does your staff handle per year?_____

In the counties you serve, how many suicide deaths occurred in each age group in 1985?

5-9_____ 10-14_____ 15-19_____ 20+_____

II. SERVICES OFFERED

Hours of operations: 24 Hours/Day ☐ or Less ☐ _____ (specify)

7 Days/Week ☐ or Less ☐ _____

Does your agency provide the following suicide related services?

Hotline ☐

Referrals ☐

Walk-in ☐

Assistance to Schools:

In-service Training Programs ☐

Parent Awareness Programs ☐

Student Awareness Programs ☐

In-School Counseling for Surviving Friends of Suicide Deaths ☐

In-School Counseling for Faculty After a Student Suicide ☐

Assistance in Implementing School Suicide Prevention Programs ☐

In what areas, other than suicide, do you provide services to your school districts?

_____

_____

Please list ISDs for which you presently provide services. _____

_____

III. RESPONSIBILITY

Please rank order the groups you believe should provide the leadership in your community's response to the tragedy of youth suicide. (Rank from most important, #1, to fifth in importance, #5.)

_____ State Government

_____ Federal Government

_____ Local Mental Health Agencies

_____ Local School Districts

_____ Suicide Crisis Centers

Please rank order the persons you believe should provide the leadership in your community's response to the tragedy of youth suicide. (Rank from most important, #1, to fifth in importance, #5.)

_____ Teachers

_____ Parents

_____ Ministers

_____ School Counselors

_____ Local Mental Health Professionals

Please indicate your level of agreement or disagreement to the following statements by circling the appropriate number.

(a) Schools should participate in the prevention of youth suicide.

(1)	(2)	(3)	(4)	(5)
Strongly Agree	Agree	Indifferent	Disagree	Strongly Disagree

Continued on next page.

(b) Schools should participate in youth suicide intervention.

(1)	(2)	(3)	(4)	(5)
Strongly Agree	Agree	Indifferent	Disagree	Strongly Disagree

(c) Schools should participate in youth suicide postvention.

(1)	(2)	(3)	(4)	(5)
Strongly Agree	Agree	Indifferent	Disagree	Strongly Disagree

(d) School counselors are qualified to provide suicide prevention services.

(1)	(2)	(3)	(4)	(5)
Strongly Agree	Agree	Indifferent	Disagree	Strongly Disagree

(e) School counselors are qualified to provide suicide intervention services.

(1)	(2)	(3)	(4)	(5)
Strongly Agree	Agree	Indifferent	Disagree	Strongly Disagree

(f) School counselors are qualified to provide suicide postvention services.

(1)	(2)	(3)	(4)	(5)
Strongly Agree	Agree	Indifferent	Disagree	Strongly Disagree

(g) School teachers are able to identify youths at risk for suicide.

(1)	(2)	(3)	(4)	(5)
Strongly Agree	Agree	Indifferent	Disagree	Strongly Disagree

(h) School teachers could be trained to identify youth at risk for suicide.

(1)	(2)	(3)	(4)	(5)
Strongly Agree	Agree	Indifferent	Disagree	Strongly Disagree

(i) There should be an MHMR-to-school link in combatting youth suicide.

(1)	(2)	(3)	(4)	(5)
Strongly Agree	Agree	Indifferent	Disagree	Strongly Disagree

YOUR THOUGHTS

Do you think school districts should have a comprehensive, written policy which would address suicide policies and procedures?

_____ Yes _____ No

In your view, what is the most effective way in which the community you serve might provide services for youth suicide prevention?

_____

_____

_____

In your view, what is the most effective way in which the community you serve might provide services for youth suicide intervention?

_____

_____

_____

In your view, what is the most effective way in which the community you serve might provide services for youth suicide postvention?

_____

_____

_____

Are there any additional comments that you would like to make?_____

_____

_____

_____

LINKAGES

Are there any private or public institutions in your area involved with youth suicide?

Yes _____ No _____

If there are, please list them. _____

_____

_____

_____

_____

APPENDIX F

The Texas Family Code, Section 35.03

AN ACT relating to the consent of minors and others to treatment by a physician, psychologist, counselor, or social worker in cases involving sexual abuse, physical abuse, or suicide prevention; adding Subsection (g) to Section 35.03, Family Code, as amended.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Section 35.03, Family Code, as amended is amended by adding Subsection (g) to read as follows:

"(g) A minor may consent to counseling by a physician, psychologist, counselor, or social worker licensed or certified by this state, within the scope of the professional's license, if the minor consents to treatment for sexual abuse, physical abuse, or suicide prevention.

"(1) Except as provided in subdivision (4) of this subsection, a physician, psychologist, counselor, or social worker licensed or certified by this state having reasonable grounds to believe that a child has been sexually or physically abused and/or is contemplating suicide may counsel the child without consent of the child's parents, managing conservator, or guardian.

"(2) A physician, psychologist, counselor, or social worker licensed or certified by this state may, with or without the consent of a minor who is a client, advise the parents, managing conservator, or guardian of the minor of the treatment given or needed by the minor.

"(3) A physician, psychologist, counselor, or social worker licensed or certified by this state may rely on the written statement of the minor containing the grounds on which the minor has capacity to consent to his or her own treatment under this section.

"(4) Unless consent is obtained as otherwise allowed by law, a physician, psychologist, counselor, or social worker licensed or certified by this state may not counsel a child if consent is refused by an order of a court.

"(5) A physician, psychologist, counselor, or social worker licensed or certified by this state and counseling a child under the authority of this section is not liable for damages except those damages resulting from his or her negligence or willful misconduct.

"(6) A parent, managing conservator, or guardian is not obligated to compensate a physician, psychologist, counselor, or social worker for counseling services rendered under Subsection (g) of this section without the prior consent of the parent, managing conservator, or guardian."

SECTION 2. This Act takes effect September 1, 1985.